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the West Virginia Medical Journal

OFFICIAL ORGAN OF
WEST VIRGINIA STATE
MEDICAL ASSOCIATION

Vol. 65 No. 1

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Vol. 65 No. 1

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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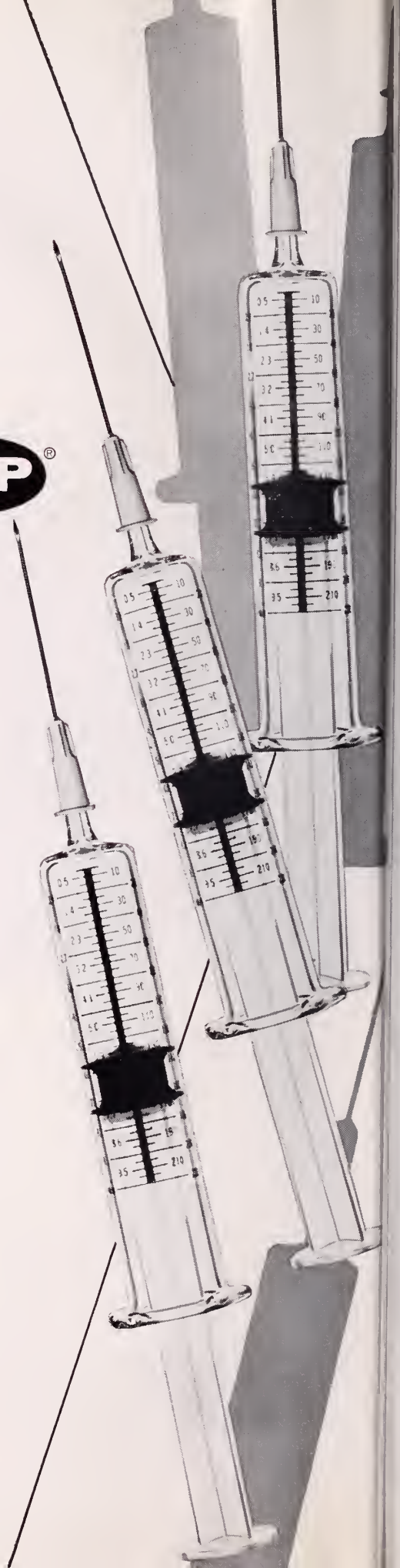

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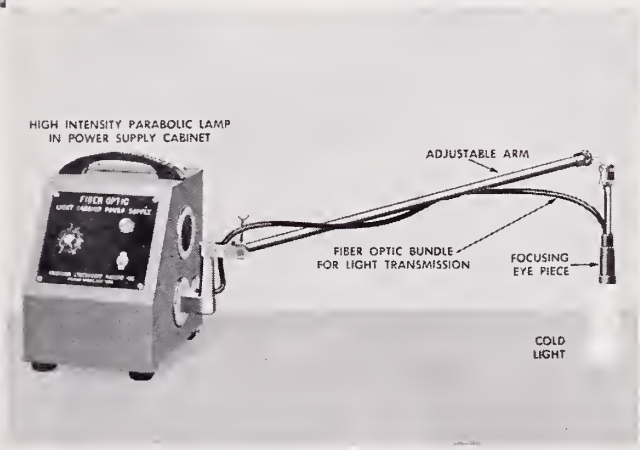

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WVU Medical Center
—News—

Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery, is serving a voluntary two-month tour aboard the hospital ship S. S. HOPE.

Bernard Zimmermann, M. D.

Doctor Zimmermann joined the HOPE on December 13 in Colombo, Ceylon. He is among 1,200 American medical personnel who have volunteered their services to train almost 4,500 medical counterparts in seven developing nations since the HOPE's first voyage in 1960.

Visiting Lecturer from Germany

West Virginia University's Institute of Biological Sciences sponsored a visit on December 20 by a prominent scientist from Tubingen, Germany.

Dr. G. F. Meyer of the University of Tubingen presented a public lecture on "Activity of the Y-Chromosome on Sperm Differentiation."

WVU Admits Patient No. 100,000

Mrs. Helen Jarvis of the Nicholas County community of Tioga on November 26 became the 100,000th patient to be admitted by WVU Hospital since it was opened eight years ago.

The hospital opened on August 10, 1960. The first patient, Mrs. Madge Lawson, resides in Buckhannon.

One of every 25 residents of the State has been treated at University Hospital, and 85 per cent of those admitted are from West Virginia.

Doctor Chang Elected By Society

Dr. C. H. Joseph Chang, Associate Professor of Radiology, was elected to membership in the Society for Pediatric Radiology at the group's annual meeting recently in New Orleans.

Physicians Attend ACP Regional

Four WVU Medical Center physicians presented papers at a regional meeting of the American College of Physicians, which was held in Pittsburgh, November 22-23. The meeting was for ACP members in Western Pennsylvania, Ohio and West Virginia.

Dr. Charles L. Jacobson of the Division of Endocrinology and Metabolism presented an extension of studies he reported November 2 at a meeting in Chicago. Dr. John E. Jones, Division Chairman, is coauthor of the paper entitled "Reduced Testosterone Binding in Women and Amenorrhea and Hirsutism."

Dr. Edmund B. Flink, Chairman of the Department of Medicine and ACP Governor for West Virginia, presented a paper called "Effect of Phosphate on Glucose-Induced Excretion of Magnesium and Calcium."

Dr. Edward K. Chung, Associate Professor of Medicine, reported on "Digitalis-Induced Cardiac Arrhythmias," and Dr. Paul Davidson, Assistant Professor of Medicine, talked on "Maximal Beta Cytotrophic Response in Man."

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Hospital Group Elects Mr. Staples

Mr. Eugene L. Staples, Director of University Hospital, has been named President Elect of the West Virginia Hospital Association.

Elected in October, Mr. Staples will succeed Mr. Joseph E. Peery of Welch as President next year.

Conference on Health Care Costs

Mr. Eugene L. Staples, Director of University Hospital, participated in a Regional Conference on Health Care Costs in Harrisburg, Pennsylvania, December 10-11.

Called on a nationwide basis by HEW Secretary Wilbur J. Cohen, such conferences are designed to "bring together leaders of the health community and the insurance industry, consumers and purchasers (both Government and public) to approach problems of rising health care costs . . ."

Visiting Lecturers

Dr. F. Clarke Fraser, renowned geneticist, lectured at the Medical Center on November 15.

Doctor Fraser, Professor of Human Genetics at McGill University and Director of the Department of Medical Genetics at The Montreal Children's Hospital, spoke on "Genetics of Common Congenital Malformations."

Dr. John D. Crawford, Associate Professor of Pediatrics at Harvard Medical School, presented a public lecture at the Medical Center on November 22. The author of 129 publications, Doctor Crawford explored the question of whether the pediatrician has a role in the prevention of morbidity and mortality in middle age.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE incoming Administration work on a health program was started with President Elect Richard Nixon's appointment of John Dunlop, a Harvard University professor, to head a special task force. Dunlop is a prominent economist and an expert in the manpower field. He has been a frequent adviser to the federal government since 1948.

In a letter to employes of the Department of Health, Education and Welfare, Secretary Wilbur J. Cohen, who will return to teaching at the University of Michigan, listed 13 health goals for the 1970s. He previously had said that his teaching position would leave him time to work for new and expanded health programs.

Most of the goals are non-controversial, and Cohen did not elaborate on details of implementation where controversy arises. The goals:

—Continued expansion of medical research and more rapid dissemination of new knowledge to prevent and cure illness.

—Elimination of economic barriers to medical care, through comprehensive health insurance and other public and private programs.

—Major reduction in infant mortality and early childhood diseases.

—Elimination of malnutrition.

—Improvement in the organization and delivery of medical care, with continued emphasis on high quality.

—Widespread transplantation of human organs and development of artificial organs.

—Expanded prevention and improved chances of recovery from heart disease, stroke and cancer.

—Increase of health manpower and better use of professional skills.

—Elimination of large mental institutions and expansion of community mental health centers accessible to all.

—Family planning services available to everyone.

—Improvement in the quality of the environment, with major reduction in air and water pollution.

—Reduction of alcoholism, drug addiction, mental illness and mental retardation, and accidents.

—Elimination of smallpox, diphtheria, polio, whooping cough and measles.

Developments in the Drug Field

Developments in the drug field include starts on tests of an old drug in treatment of pneumonia and a new one for Parkinson's disease.

The National Institutes of Health started a widespread test of a polyvalent pneumoncoccal vaccine that was discarded 20 years ago with the entrance of antibiotics. Edwin M. Lerner, M. D., Coordinator of the test program, said it had been demonstrated that persons die of pneumonia because of early stage damage and that antibiotics have not been a cure-all. The old vaccine, manufactured by E. R. Squibb and Sons, was licensed and found effective in 1948, but was taken off the market in 1952 because of lack of sales.

"Penicillin was the cure-all in those days," Doctor Lerner said. "It was felt that there was no need to vaccinate people. After all, we thought we could cure them."

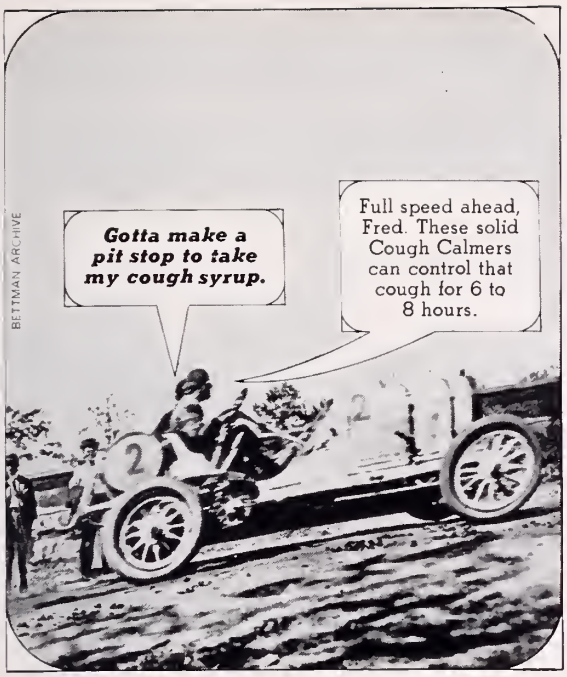
The Public Health Service announced a program to test an experimental drug in treatment of Parkinson's disease. Robert Q. Marston, M. D., Director of the National Institutes of Health, said the drug, L-DOPA, may help "up to 75 percent of patients." But he cautioned it has "serious and unpleasant side effects" which must be carefully checked.

Other developments in the drug field:

—The Pharmaceutical Manufacturers Association disputed the finding of an HEW Task Force on Drugs that a $41.7 million saving could have been obtained by use of generic instead of brand name products in 67 or the 409 prescription drugs used most often by elderly persons. C. Joseph Stetler, PMA president, said the claim was not documented and was based "on the unproven assumption that prescriptions written by generic name cost substantially less."

—A Food and Drug Administration Advisory Committee said that existing data on whether birth control pills can cause cancer of the cervix is still inconclusive. The Advisory Committee on Obstetrics and Gynecology repeated the recommendation of the World Health Organization that all women using birth control pills undergo six-to-12 month medical examinations.

—The government has drawn up a national drug system to permit computerized processing of drug data. The code is designed to provide the needed common language in which to communicate rapidly and accurately essential information about drugs. The code was drawn up by HEW and the Drug Trade Conference, which represents drug manufacturers and distributors.



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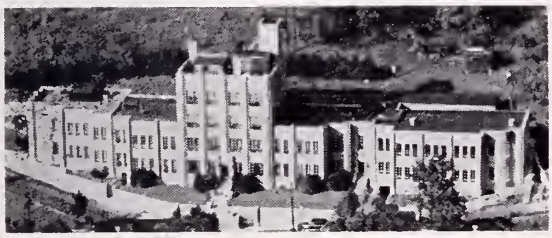

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County Societies

FAYETTE

Dr. Worthy W. McKinney of Beckley was guest speaker at the regular monthly meeting of the Fayette County Medical Society, which was held at the Oak Hill Hospital on December 4.

Doctor McKinney gave an interesting scientific talk on "Office Ophthalmology," and as a member of the Council of the State Medical Association, he briefed Society members on programs of the Association.

Dr. M. G. Hresan was elected President of the Society for the coming year. Dr. Ivan H. Bush, Jr., was named Secretary-Treasurer.—A. R. Bautista, M. D., Secretary.

* * * *

KANAWHA

Dr. Charles E. Andrews of Morgantown was guest speaker at the regular monthly meeting of the Kanawha Medical Society, which was held in Charleston on November 12.

Doctor Andrews, Professor of Medicine and Provost of Health Sciences at West Virginia University, gave an interesting presentation on "Black Lung Disease."

The Nominating Committee presented the name of Dr. A. Thomas McCoy as its choice for President of the Society for the coming year. The election will be held later.

* * * *

MERCER

Dr. Shelton Horsley, III, was guest speaker at the regular monthly meeting of the Mercer County Medical Society, which was held in Bluefield on November 18.

Doctor Horsley, Associate Professor of Surgery at the University of Virginia Hospital, gave an informative talk on "Palliative Treatment of Breast Cancer."

The Nominating Committee recommended a slate of Society officers for the coming year, and the report was approved. Dr. James E. Powers was elected President; Dr. William M. Bruch was named Vice President; and Dr. John J. Mahood was named to another term as Secretary-Treasurer.—John J. Mahood, M. D., Secretary.

* * * *

McDOWELL

A joint dinner meeting of the McDowell County Medical Society and the Woman's Auxiliary was held in Welch on November 13.

During the business meeting, the following physicians were named to serve as officers of the Society during the coming year:

Dr. J. H. Murry of Gary, President; Dr. R. O. Gale of Welch, Vice President; Dr. J. C. Ray of Welch, Secretary; and Dr. Robert W. Hansen of Welch, Treasurer.—J. C. Ray, M. D., Secretary.

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MONONGALIA

Dr. Harold Selinger of Charleston was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on November 5.

Doctor Selinger, who is Director of the Bureau of Heart Disease Control, State Department of Health, gave a most interesting talk concerning the various programs of the Bureau. The programs include rheumatic fever control, various support of cardiac clinics throughout the State, the experimental usage of a phonocardioscan as well as an EKG scan and multiphasic autoanalyzer.—W. Gene Klingberg, M. D., Secretary.

* * * *

RALEIGH

Dr. James O. Merritt and Dr. D. Alene Blake were the speakers at the regular monthly meeting of the Raleigh County Medical Society which was held at Henry's Restaurant in Beckley on November 21.

Drs. Merritt and Blake discussed the mental health program in the nine-county area and their remarks were followed by a question and answer period.

During the business meeting, Dr. Forrest A. Cornwell was elevated to the Presidency of the Society and Dr. Walter E. Klingensmith was named President Elect. Dr. John M. Daniel was elected Secretary-Treasurer—Walter E. Klingensmith, M. D., Secretary-Treasurer.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. John A. B. Holt, Charleston
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Northern Regional Director: Mrs. Herbert Dickie, Wheeling
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Treasurer: Mrs. William T. Lawson, Fairmont
Recording Secretary: Mrs. Richard G. Starr, Beckley
Corresponding Secretary: Mrs. James H. Walker, Charleston
Parliamentarian: Mrs. George A. Curry, Morgantown

HARRISON

"Maligayang Pasko" (Merry Christmas) was the topic of the special Christmas program presented by Dr. and Mrs. Julian Gasataya for the members and guests of the Woman's Auxiliary to the Harrison County Medical Society on December 5 at the Stonewall Jackson Hotel in Clarksburg. Approximately 45 persons attended.

Doctor Gasataya, a local physician, is a native of the Philippine Islands. He spoke about the Christmas customs and traditions of his homeland. He gave a brief resume of the history of the Islands and, with the assistance of his wife, showed slides of the Phil-

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Beckley Mental Health Center
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W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

ippines taken during their visit there at the Christmas season last year.

A beautiful collection of numerous articles handmade in the Islands were on display. They included clothing, slippers, accessories, dolls and hand-carved wooden items, mainly from the Gasataya home.

A brief business meeting was held following the program, with Mrs. Robert S. Wilson, president, presiding.—Mrs. Robert D. Hess, Press and Publicity.

* * * *

MONONGALIA

Dr. Manford Sonstegard of the College of Human Resources at West Virginia University was guest speaker at the November meeting of the Woman's Auxiliary to the Monongalia County Medical Society.

Doctor Sonstegard discussed the subject of family counseling, describing the facilities which are available to children and parents in the Morgantown area.

Mrs. W. Merle Warman, Auxiliary President, presided at the session and hostesses were Mesdames Robert J. Fleming, Maynard P. Pride, Hubert A. Shaffer and D. Franklin Milam.

Change of Address

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AVAILABLE—General surgeon upon completion of training in July 1969. Filipino, married, with ECFMG Certificate. Presently doing preceptorship to complete board requirements. Write: Roberto B. De Ocampo, M. D., 40 Prospect Avenue, Norwalk, Connecticut 06850.

WANTED—Eye, Ear, Nose and Throat physician to take over practice of recently deceased physician in Wheeling. Office completely equipped and ready for immediate occupancy. Contact Mr. Joseph M. Follen, 40 12th Street, Wheeling, W. Va. 26003.

AVAILABLE—Urologist, 31, married, two children. University trained and some research experience. Available June, 1969. Will consider any urological position in West Virginia. Write JYC, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Urgent need for a physician to work in a 50-bed hospital in a small and pleasant community near Charleston. Live in or near hospital. Must be licensed in West Virginia. Prefer middle age or older physician in good health. Write DAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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FEBRUARY
1969

Vol. 65 No. 2

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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DIARRHEA

WVU Medical Center
—News—

The Fifth Annual Cancer Teaching Day will be held in the Main Auditorium at the WVU Medical Center in Morgantown on Friday and Saturday, April 18-19.

Theme for the program will be "Diagnosis and Treatment of Carcinoma of the Cervix."

The Friday afternoon session will begin at 4 P.M. and will feature a panel on "Treatment of Carcinoma of the Cervix." Moderator will be Dr. Alvin L. Watne, Professor of Surgery at WVU.

The Saturday session will begin at 9 A.M. and end by 1 P.M.

The meeting is sponsored by The Charleston Foundation, the Cancer Committee of the West Virginia State Medical Association, the West Virginia Division of the American Cancer Society, the WVU Medical Center and the West Virginia Chapter, American Academy of General Practice.

Additional information about the program will appear in the March or April issue of *The Journal.*

Public Health Service Research Grants

Several new research grants and renewals sponsored by the U. S. Public Health Service were recently received by the Medical Center. The projects, principal investigators and their departments are as follows:

"Tolerance to Cholinesterase Inhibitors"—Dr. Joseph J. McPhillips, Pharmacology.

"Stress and Drug Metabolism"—Dr. Robert E. Stitzel, Pharmacology.

"Role of Magnesium in Delirium Tremens"—Dr. Edmund B. Flink, Medicine.

"Opossum Immunology"—Dr. Robert G. Burrell, Microbiology.

"New Potential Anti-Tumor Agents"—Dr. Frederick Lotspeich, Biochemistry.

"Trematode-Arthropod Interrelationships"—Dr. John E. Hall, Microbiology.

"Afferent Nerve Pathways in the Brain and Spinal Cord"—Dr. Donald L. Kimmel, Anatomy.

"Laboratory Diagnosis of Lymphocytic Choriomeningitis"—Dr. Billy E. Kirk, Microbiology.

Program on Hemophilia

A program on "What You Should Know About Your Child's Illness" was presented for about 30 parents at the Medical Center recently.

The parents are members of the West Virginia Chapter of the Hemophilia Foundation.

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

Dr. Barbara Jones, Professor of Pediatrics and a member of the Chapter's Medical Advisory Board, arranged the meeting. Speakers in addition to Doctor Jones incuded: Dr. J. C. Pickett, Chairman of the Division of Orthopedic Surgery; Robert Frank of the Physical Therapy Department; Dr. John Welch of the Department of Oral Surgery; Dr. John Kelley of the Department of Psychiatry; and Dr. Mabel Stevenson of the Department of Clinical Pathology, Director of University Hospital's Blood Bank.

A question and answer period and social hour followed the program, and the Blood Bank remained open for donations.

Doctor Jones said the meeting was so successful that another program will be conducted later in the year for parents who could not attend.

New Medical School Program

A program which hopefully will benefit citizens of western Monongalia County and WVU medical students alike has been begun by the WVU School of Medicine.

First-year medical students are participating in what is known as the Clay-Battelle Project, named after two of Monongalia County's magisterial districts.

With cooperation from local groups, each first-year student was assigned a family selected at random from the two districts. The students first conducted interviews with their families, which they are to follow throughout their four years in Medical School.

Before health needs of the area could be fully determined, each participating family was asked to undergo a physical examination. In a specially equipped office in Wadestown, examinations are being conducted by senior medical students with faculty physicians in charge and the first-year students acting as observers.

"The Clay-Battelle Project is especially valuable," said Dr. Marilyn Jarvis-Eckert, Assistant Professor of Preventive Medicine, "Because it allows the student to observe the family in the home, something he could not otherwise do in his four years in medical school. It provides an over-all view, an interrelation between learning about and doing for people."

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The Month in Washington

A House Ways and Means Committee member introduced on the first day of the new Congress a bill that would provide federal income tax credits to help individuals buy private health insurance. The legislation (HR 19), sponsored by Rep. Richard Fulton (D., Tenn.), was similar in principle to a health insurance financing plan utilizing tax credits approved by the American Medical Association House of Delegates at San Francisco last June and reaffirmed at Miami Beach last December.

Fulton said he considered his bill "at least an opener" for hearings.

"Certainly before expanding any federal program, I believe it worthwhile to explore the use of the private sector and our tax system," Fulton said.

The Fulton bill provides that individuals with incomes of $2,500 or less and families with incomes of $5,000 or less would receive $150 vouchers from the federal government per eligible individual for the purchase of health insurance. The family maximum would be $400.

In the case of a taxpayer with an income between $2,500.01 and $5,000, or a family with an income between $5,000.01 and $7,500, the credit would be a 75 per cent per eligible individual with a maximum of $400 per family.

In the case of a taxpayer with an income of $5,000.01 to $7,500, or a family with an income between $7,500.01 and $10,000, the credit would be 50 per cent per eligible individual with a $400 family maximum.

In the case of a taxpayer with an income exceeding $7,500.01, or a family with an income exceeding $10,000.01, the credit would be 25 per cent.

At San Francisco, the House of Delegates adopted as approved AMA policy "the principle of graduated income tax credits for premiums paid for adequate health insurance." A resolution adopted at Miami Beach called upon the AMA to "vigorously promote the enactment of federal legislation implementing" the plan.

Mutual Cooperation Needed

A special commission on health facilities concluded that government and private enterprise must cooperate to organize the nation's health resources into effective, efficient and economical community systems of comprehensive health care for all persons.

The National Advisory Commission on Health Facilities, established in October, 1967, drafted its report to the President in general terms and did not make any recommendations for legislation.

• **From the Washington Office of the American Medical Association.**

A summary of the report included:

"America's health care system should combine private and public responsibility. Facilities and systems will vary from community to community in accordance with local capacities and local needs, but guiding principles should govern the effort to develop effective and efficient health care systems:

"1. These systems should be organized to assure appropriate points of entry into and continuity of health care services.

"2. Every citizen should have ready access to quality health care.

"3. States, regions, local communities, and all health institutions should carry out continuous planning.

"4. Both those who provide and consume health services should participate in the decisions.

"5. All levels of health care should be interdependent."

Medicare Developments

A Health, Education and Welfare Department report to Congress recommended that preventive health care services not be added to Medicare benefits at this time.

The report cited as reasons for the negative recommendation: administrative constraints, inability to estimate costs, limited experience with automated multi-phasic health screening, and an inadequate supply of health professionals.

The report was one of three requested by Congress last year and submitted before the change in Administration.

A second report dealt with coverage of mentally ill under Medicare but did not include any recommendations.

The third reviewed qualifications of personnel under current Medicare regulations. It stated that, because of an acute manpower shortage in the field, physical therapists should be considered qualified if they could establish an adequate level of competency. HEW is developing a proficiency examination.

HEW recommended against allowing licensed practical nurses to serve as nurses responsible for the total nursing care at an extended care facility. It also recommended against changes in the regulations that set minimal standards for independent laboratory personnel.

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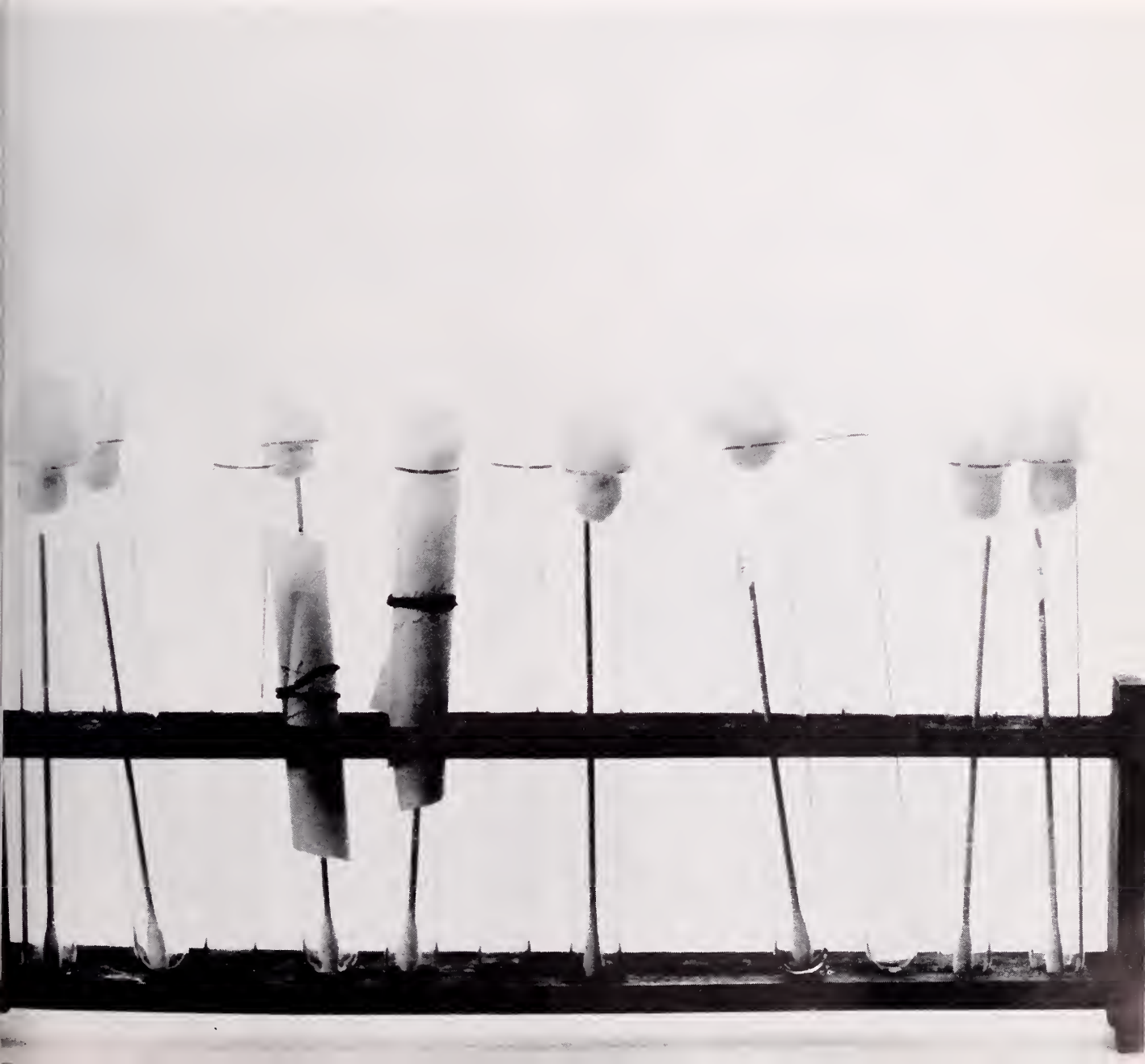

Obituaries

PERCY RYLAND FOX, M. D.

Dr. P. R. Fox of Bluefield died in a hospital in that city on December 16 at the age of 76. He had been hospitalized about a month before after suffering a fall at his home.

A native of King William County, Virginia, Doctor Fox received his M.D. degree in 1923 from the Medical College of Virginia.

He was a Past President of the Mercer County Medical Society. He was an honorary member of the West Virginia State Medical Association and the American Medical Association, and his other professional memberships included the Virginia Medical Society and the Richmond Academy of Medicine.

Doctor Fox leaves his widow, Mrs. Nina Kelly Fox; two daughters, Mrs. Nina Carolyn Shanklin of Charlottesville, Virginia, and Rebecca Ryland Fox, a student at the University of Tennessee; a brother, Nelson M. Fox of Dunnsville, Virginia; and one grandchild.

* * * *

EDWARD D. GIBSON, M. D.

Dr. Edward D. Gibson, 66, of Lighthouse Point, Florida, died in that state of an apparent heart attack on December 22.

A native of Wyatt, Missouri, Doctor Gibson had been engaged in general practice in the McDowell County community of Iaeger before retiring to Florida about four years ago.

He received his M.D. degree from the University of Louisville School of Medicine in 1932 and served his internship at Louisville City Hospital.

He was a member of the McDowell County Medical Society, of which he was President in 1948; the West Virginia State Medical Association; and the American Medical Association.

Survivors include the widow, Mrs. Imajean C. Gibson; a son, Dr. Edward Gibson, Jr., of Lakeland, Florida; a daughter, Mrs. Betsy Brutigan of Pompano Beach, Florida; five sisters, Mrs. Lois Palmer of Salem, Virginia, Mrs. George Stringer and Mrs. Edward Jacobson of Los Angeles, California, Mrs. Dale Carson of Eugene, Oregon, and Mrs. Lawrence Lukens of Kalmath Falls, Oregon; and five grandchildren.

* * * *

HOMER DELMAR MARTIN, M. D.

Dr. Homer D. Martin of Dailey, Randolph County, died on December 29 at University Hospital in Morgantown. He was 51.

Doctor Martin, a native of Montrose, had become ill the day before at his home. Death was attributed to a cerebral hemorrhage.

He attended West Virginia University, where he received an A.B. degree in 1940 and a B.S. degree in 1948. In the interim, he served as a Captain in the U. S. Army Air Corps.

After receiving his M.D. degree from the Medical College of Virginia in 1951, Doctor Martin served an internship at Stuart Circle Hospital in Richmond, Virginia.

He was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association, the American Medical Association, the American Academy of General Practice and the Southern Medical Association. In 1965-66, he was President of the Barbour-Tucker-Randolph Tri-County Medical Society before it was consolidated with the Taylor County Medical Society to form the Tygart's Valley group.

Survivors include: the widow, the former Annis Hill King; the mother, Mrs. Amaretta Clark Martin of Elkins; a son, Homer D. Martin, Jr., a high school student in Alexandria, Virginia; brothers, Roscoe R. Martin of Elkins, Col. Ersel E. Martin, with the U. S. Army in Chicago, Carroll E. Martin of Elkins, Robert G. Martin of Philadelphia, and Donald P. Martin of Weston; and two sisters, Mrs. Fern Graves of Hollywood, California, and Miss Opal Martin of Elkins.

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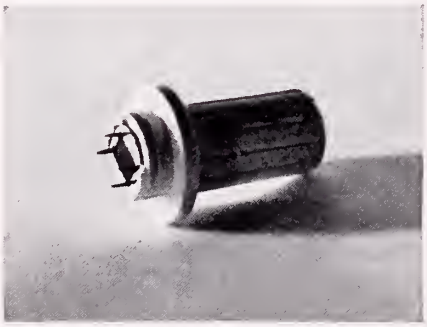

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County Societies

EASTERN PANHANDLE

Dr. Leo H. T. Bernstein of Martinsburg was elected President of the Eastern Panhandle Medical Society at its regular December meeting at the Gateway Inn in Martinsburg.

He succeeds Dr. William Rodgers.

Other new officers for the coming year are: Dr. Mildred Williams of Charles Town, First Vice President; Dr. Bernadino Marcelo of Berkeley Springs, Second Vice President; and Dr. Robert Pittman of Martinsburg, Secretary-Treasurer.

* * * *

MERCER

The annual Christmas Banquet of the Mercer County Medical Society was held at the Bluefield Country Club on December 19.

Dr. C. D. Pruett, retiring President of the Society, welcomed the wives of members and several guests.

Dr. James E. Powers of Princeton was installed as President to succeed Doctor Pruett.—John J. Mahood, M. D., Secretary.

* * * *

McDOWELL

The McDowell County Medical Society held its annual Christmas dinner and dance at the Gary Country Club on December 14.

More than 100 persons attended.—Joseph C. Ray, M. D., Secretary.

* * * *

MONONGALIA

Dr. Robert Greco of Morgantown was elected President of the Monongalia County Medical Society at the regular monthly meeting which was held on December 3.

Other new officers for this year are: Dr. Charles E. Andrews, President Elect; Dr. Carl H. Cather, Vice President; Dr. W. Gene Klingberg, Secretary; and Dr. John H. Trotter, Treasurer—W. Gene Klingberg, M. D., Secretary.

PARKERSBURG ACADEMY

The Annual Dinner Dance of the Parkersburg Academy of Medicine was held at the Chanceller Hotel in Parkersburg on January 9.

Dr. Richard W. Corbitt of Parkersburg addressed his "home" medical society in his role as President of the West Virginia State Medical Association. Doctor Corbitt discussed the candidacy of Dr. C. A. Hoffman of Huntington for the Vice Speakership of the American Medical Association House of Delegates and also urged physicians in attendance to attend the State Association's Annual Meeting at The Greenbrier next August.

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MARCH
1969

Vol. 65 No. 3

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1969

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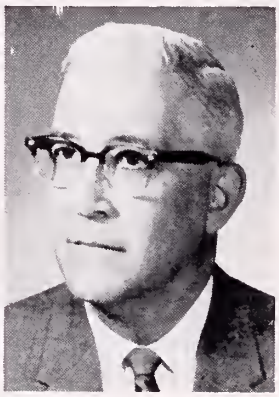
DOW

WVU Medical Center
–News–

• **Compiled from materiol furnished by the Medical Center News ond Informotion Services, Morgontown, West Virginio.**

DR. Richard V. Lynch, Jr., Immediate Past President of the West Virginia State Medical Association, has closed his medical practice in Clarksburg and has joined the faculty and staff of the West Virginia University Medical Center in Morgantown.



Richard V. Lynch, Jr., M. D.

Doctor Lynch assumed duties as Assistant Professor of Medicine and Chief of University Hospital's Outpatient Department.

The appointment was announced by Dr. Charles E. Andrews, Provost of Health Sciences at WVU.

"We think Doctor Lynch is uniquely qualified for the job," Doctor Andrews commented. "He is a good physician and he understands the problems and needs of practitioners."

In his role as Chief of the Outpatient Department, Doctor Lynch will coordinate referrals and supervise new directions in services, as well as oversee all other aspects of the Department's operation.

A native of Clarksburg, Doctor Lynch received his A. B. degree from West Virginia University and earned his M. D. degree at the University of Pennsylvania Medical School. He has been practicing internal medicine in Clarksburg for almost 20 years.

For many years Doctor Lynch has been active in professional, service and civic organizations. He was elected to two four-year terms on the Clarksburg City Council.

In organized medicine, Doctor Lynch served one year as President of the Harrison County Medical Society, and in 1960, he was elected to the Council of the West Virginia State Medical Association. He was named Vice President in 1965, President Elect in 1966 and President in 1967. He is now Chairman of the Council of the State Medical Association.

He also has given freely of his time and service to various voluntary health organizations. He is a Past President of the West Virginia Tuberculosis and Health Association, the West Virginia Thoracic Society, and the West Virginia Diabetes Association. At the present time, he is President Elect of the West Virginia Heart Association.

During World War II, Doctor Lynch served as a Captain in the Medical Corps of the United States Army and currently holds the rank of Lieutenant Colonel in the Medical Corps of the Air Force Reserve.

Doctor Lynch is married to the former Mary M. Horner, and they have two sons.

Heart Screening Examinations

All first-grade children in Monongalia County are undergoing a heart screening examination. Drs. Roland Schmidt, George Khoury and Michael Hunsaker, all cardiologists at the Medical Center, are conducting the examinations in cooperation with the Monongalia County School Superintendent's office.

PTA volunteers and nurses from the Monongalia County Health Department are assisting with the project.

Paper on Otolaryngology

Dr. Philip M. Sprinkle, Professor and Chairman of the Division of Otolaryngology, and Dr. Robert Veltri, Assistant Professor of Microbiology, have been selected to present a program at the meeting of the American Academy of Otolaryngology, which will be held in Chicago next October.

The title of their first presentation, scheduled for October 12, will be "The Microbiology and Immunology of the Oropharynx."

Cancer Grant

Michael G. Farrow, doctoral candidate in human genetics of the Genetics and Developmental Biology Program of WVU's Institute of Biological Sciences, has been awarded a Cancer Training Fellowship.

The Graduate Cancer Training Grant Committee awarded the grant for research on "The Effect of Chemotherapeutic Drugs on Human Chromosomes from Normal and Leukemic Cells."

Dr. William J. Canady, Associate Professor of Biochemistry, recently received a research grant from the National Science Foundation for a project entitled, "Thermodynamics of Enzyme-Substrate and Enzyme-Inhibitor Interactions."

Paper Presented

Dr. Hiroshi Suzuki, Assistant Professor of Pathology, presented a paper on February 26 at an interim meeting of the American Society of Clinical Pathologists.

The presentation, "Cysts of the Parathyroid Glands: Report of 32 Cases and Review of the Literature," covers studies Doctor Suzuki had conducted during the past four years under a General Institutional Grant of the School of Medicine.

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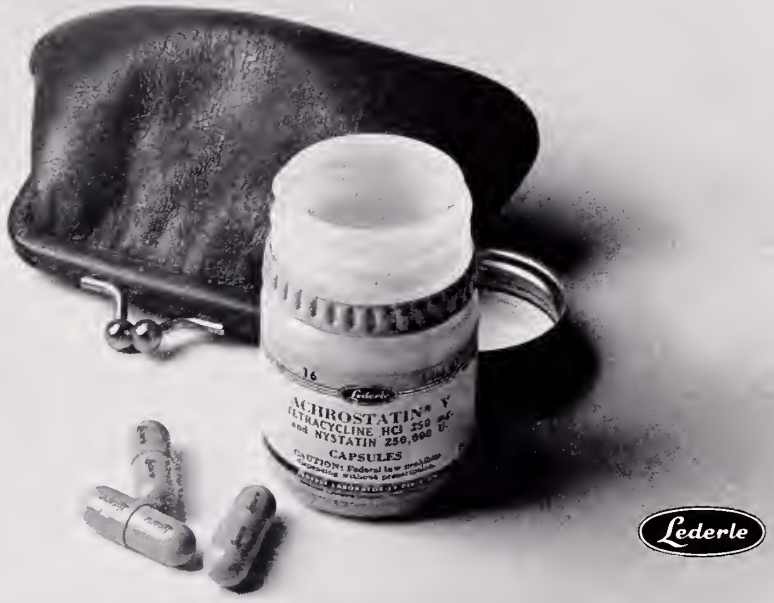

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The Month in Washington

• From the Washington Office of the American Medical Association.

A Federal Communications Commission proposal to ban cigarette advertising on radio and television put the issue squarely before Congress again.

In 1965, Congress outlawed any federal or state controls on cigarette ads as a provision of the legislation that made mandatory that cigarette packages carry the warning: "Caution: Cigarette Smoking May be Hazardous to Your Health." Proponents of the electronic advertising ban contend that the package warning doesn't make enough impact.

Even before the FCC announcement, some members of Congress were saying that the provision outlawing federal and state controls over cigarette advertising should be allowed to expire on June 3. However, congressional reaction to the FCC ruling was mixed.

AMA Policy

The American Medical Association House of Delegates, at its meeting in Miami Beach last December, declined to approve a resolution condemning cigarette advertising on TV. Instead, it adopted a resolution urging that AMA members "play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking." The adopted resolution also made it Association policy that the AMA "discourage smoking by means of public pronouncements and educational programs" and "take a strong stand against smoking by every means at its command."

Anticipating censorship charges — which came promptly from the tobacco and broadcasting industries, and some members of Congress, the FCC said in announcing its proposal:

"We believe that in the case of such a threat to public health, the authority to act is really a duty to act. We stress again that our action is limited to the unique situation and product; that we are unaware of any other product commercials calling for such action, and expressly disclaim any intention to so proceed against other product commercials."

Hong Kong Flu Epidemic

A nationwide increase in deaths from pneumonia was attributable to the Hong Kong flu epidemic, the federal government reported.

"Pneumonia-influenza deaths increased over what was expected normally over the time the flu epidemic was active," Public Health Service Surgeon General Dr. William H. Stewart said, adding the deaths included all kinds of pneumonia and that the increase was "almost universal across the country."

The National Communicable Disease Center in Atlanta said pneumonia-influenza deaths are one measurement of the severity of a flu epidemic. Reports from 122 cities during the eight weeks ended February 1 show 5,270 more pneumonia-influenza deaths than the number normally predictable during that period. The epidemic then was "on a downtrend." according to the CDC.

Health Care Costs Studied

Robert H. Finch, the new Secretary of Health, Education and Welfare, is giving health care costs a high priority in tackling the department's problems.

Even before he was sworn in as Secretary, Finch made an unannounced call on Chairman Wilbur D. Mills (D., Ark.) of the House Ways and Means Committee, which has jurisdiction over HEW's Medicare and Medicaid programs. Finch afterwards said his staff would confer with Mills' staff to consider legislation or regulations that could combat higher health care costs.

High Cost of Labor in Hospitals

"His staff and my people are going into this to see what we can do about the skyrocketing costs—especially hospitalization where 70 per cent of the costs are labor," Finch said.

The former California Lieutenant Governor said he was thinking about the pilot program in his native state — which he called a paramedical program — whereby long stays in the hospitals are shortened by putting people in intensive care centers. If hospital stays could be shortened, he said, "massive savings would result."

Mills was reported as favoring broadened Medicare benefits or hospital care to cover disabled workers, who, by nature of their disabilities, receive Social Security payments—but because they are under 65—are ineligible for Medicare. He also was reported to be concerned over increases in hospital charges and doctors' fees.

Several members of Congress have expressed concern over increases in the federal costs of Medicare and Medicaid. The Johnson Administration's budget for fiscal 1970, starting next July 1, allots $6.9 billion, up $636 million, for Medicare and $3 billion, up $600 million, for Medicaid.

The Labor Department reported that medical costs, including both hospitalization and physicians' fees, rose 7.3 per cent for the calendar year 1968.

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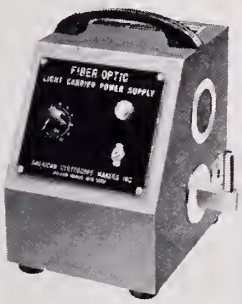

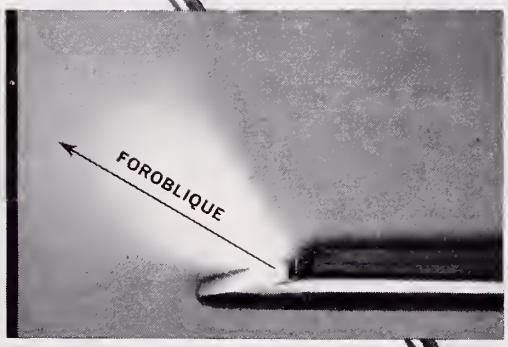

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Obituaries

CHARLES LUTHER WILBAR, JR., M. D.

Dr. Charles L. Wilbar, Jr., of Morgantown, Director of the West Virginia Regional Medical Program for Heart, Cancer, Stroke and Related Diseases, died unexpectedly on January 22 in Washington, D. C. He was 62.

C. L. Wilbar, Jr., M. D.

Doctor Wilbar was rushing to board an airplane at Washintgon National Airport when he was felled by an apparent heart attack. He was rushed to a Washintgon hospital, where he was pronounced dead on arrival.

A native of Philadelphia, Doctor Wilbar attended the University of Pennsylvania, receiving A. B. and M. D. degrees in 1928 and 1932, respectively.

He became Director of the West Virginia Regional Medical Program and Clinical Professor of Medicine at West Virginia University in 1967.

Prior to moving to Morgantown, Doctor Wilbar served as Secretary of Health in Pennsylvania under three governors. From 1943 to 1953, he was President of the Board of Health of the Territory of Hawaii.

Doctor Wilbar was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, the American Medical Association and several other organizations. He was a Diplomate of both the American Board of Pediatrics and the American Board of Preventive Medicine and Public Health. At the time of his death, Doctor Wilbar was Chairman of the Section on Preventive Medicine and Occupational Health of the AMA and was immediate past president of the American College of Preventive Medicine.

Survivors include the widow, the former Mildred Irene Robinson; two daughters, Mrs. David A. Johnston, Jr., of Hummelstown, Pennsylvania, and Mrs. Dan R. Hayes of Santa Monica, California; and three grandchildren.

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County Societies

McDOWELL

A film on "Disaster Program" was shown at the regular monthly meeting of the McDowell County Medical Society, which was held at Stevens Clinic Hospital in Welch on January 8.

Dr. J. H. Murry reported on the dental and diabetic test programs that are being conducted in McDowell County.

Ten members and one guest attended the meeting.—J. C. Ray, M. D., Secretary.

* * * *

MONONGALIA

Officers of the Student American Medical Association at the West Virginia University School of Medicine presented a program for the regular monthly meeting of the Monongalia County Medical Society, which was held on January 7.

Mr. Brooks Gainer, Regional Vice President of SAMA, and Mr. Ralph Greene, President of the WVU Chapter, provided an interesting discussion of "Aspects of SAMA." Both spoke of local SAMA activities and those of the Student Health Organization. They emphasized the concern of the medical student for community health care problems and their desire to become better acquainted with the physicians in the State.

Drs. Donald C. Dickenson, Avelino T. Sales and Otho L. Trick were admitted to membership in the Society.—W. Gene Klingberg, M. D., Secretary.

* * * *

RALEIGH

The regular monthly meeting of the Raleigh County Medical Society was held on January 16 at Henry's Restaurant with 41 members and guests in attendance.

Dr. Forest A. Cornwell of Beckley, President of the Society, announced committee appointments for his term of office.

The Society adopted a resolution calling for members to keep in touch with medical students from the area as a means of encouraging them to return home to practice.—J. M. Daniel, M. D., Secretary.

PG Course in Pediatrics In Cincinnati

The Department of Pediatrics at the University of Cincinnati will present a postgraduate course May 8-10.

The topics to be covered will include viral chemotheapy and vaccines, genitourinary tract disorders, renal transplantation, antibiotic therapy, and problems of the newborn.

A registration fee of $50 will be charged.

Inquiries about the course should be addressed to: Dr. George Benzing III, Children's Hospital, Cincinnati, Ohio.

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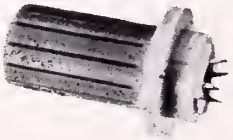

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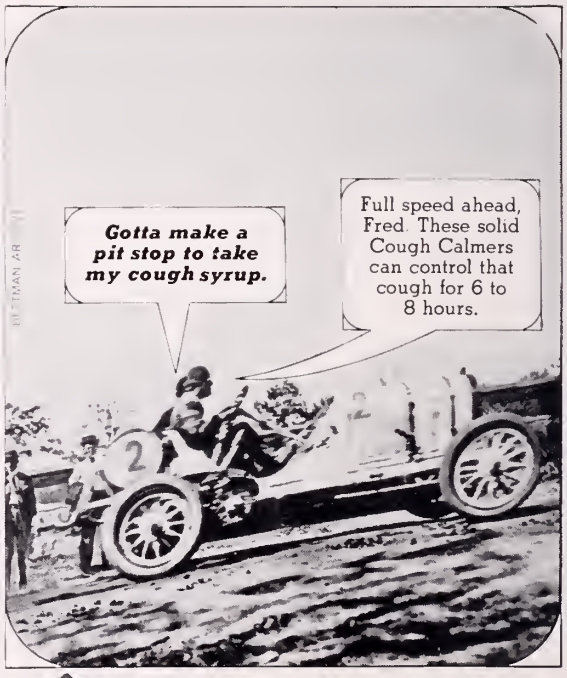

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Parliamentarian: Mrs. George A. Curry, Morgantown

HARRISON

A program on flower arrangements was presented at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg on January 2.

Mr. William H. Weber, assisted by Mrs. Louise Batman and Mr. Randy Strogen, artistically executed a variety of floral arrangements.

Mrs. Karl A. Dillinger, Vice President of the Auxiliary, presided at a brief business session.

More than 60 persons attended the meeting.

The Woman's Auxiliary to the Harrison County Medical Society sponsored a salad smorgasbord and benefit card party on February 7 at the YWCA in Clarksburg.

About 185 persons participated in the benefit, proceeds of which were donated to the West Virginia University School of Medicine through the American Medical Association Education and Research Foundation.

A committee headed by Mrs. Herman Fischer, the Auxiliary's AMA-ERF Chairman, was in charge of arrangements.—Mrs. Robert D. Hess, Publicity Chairman.

* * * *

RALEIGH

Dr. Forest A. Cornwell, President of the Raleigh County Medical Society, was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Raleigh Society, which was held at Henry's Restaurant in Beckley in January.

Doctor Cornwell spoke on "Problems and Challenges in Medicine Today."

Mrs. G. A. Bowles, President of the Auxiliary, conducted a brief business session and announced that Mrs. J. E. Blaydes, Jr., of Bluefield, a regional director for the Woman's Auxiliary to the West Virginia State Medical Association, would be a guest at the February meeting.

* * * *

TYGART'S VALLEY

Mrs. Louis Nefflen of Elkins is the first President of the newly-organized Woman's Auxiliary to the Tygart's Valley Medical Society.

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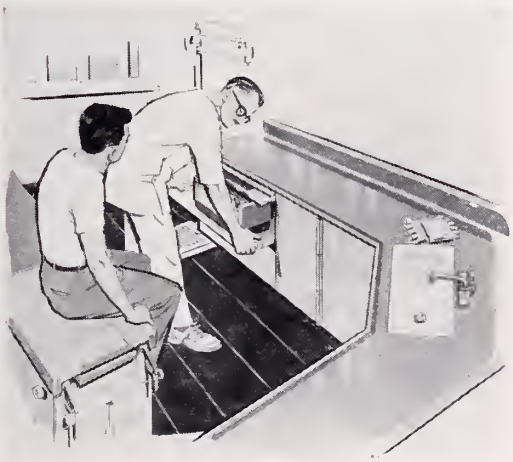

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WOMAN'S AUXILIARY—(Continued)

Mrs. Ernest Guy of Philippi is Secretary-Treasurer of the new unit, which was organized under a charter granted last August 22. Counties represented in the Tygart's Valley Auxiliary are Barbour, Randolph, Taylor and Tucker. Regular meetings will be held in October, November, March and April.

W. Va. Acad. of Oph.-Otol. Reveals Meeting Plans

The West Virginia Academy of Ophthalmology and Otolaryngology has announced plans for its 1969 National Spring Meeting, which will be held at The Greenbrier in White Sulphur Springs, April 20-23.

Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer of the Academy, said there would be eight guest speakers.

Speakers on ophthalmology will include: Dr. Irving H. Leopold of New York City; Dr. John A. Dyer of Rochester, Minnesota; Dr. Marshall M. Parks of Washington, D. C.; and Dr. Charles L. Schepens of Boston, Massachusetts.

Papers on otolaryngology will be presented by: Dr. Harold F. Schuknecht of Boston, Massachusetts; Dr. Joseph H. Ogura of St. Louis, Missouri; Dr. J. R. Chandler of Miami, Florida; and Dr. Louis E. Silcox of Philadelphia.

More than 400 physicians and guests are expected to attend the meeting.

Maryland Medical Plans April Meeting

The 171st Annual Meeting of the Medical and Chirurgical Faculty of Maryland will be held April 9-11 in Baltimore.

The Program Committee said certain changes in the format for the meeting hopefully will stimulate more interest on the part of house officers and medical students, as well as practicing physicians.

There will be no registration fee, and the American Academy of General Practice will grant credit to its members who attend the scientific sessions.

Programs may be obtained by writing to: Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore 21201.

Blood Pressure Recording Symposium Published

Copies of the proceedings of a "Symposium on Objective Recording of Blood Pressure," held January 1966 in Chicago, are now available from the American Heart Association and its affiliates.

The symposium's purpose was to update the scientific community on the stated objective recordings of blood pressure, develop a dialogue among the scientists and medical and industrial people concerned, and to elicit recommendations to stimulate needed research and development in this area.

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Book Reviews

SURGERY IN THE HEMOPHILIAC—Dr. Thomas J. Tarnay, Assistant Professor of Surgery, West Virginia University School of Medicine. Charles C. Thomas, Publisher, Illinois. 1968. Pp. 131. Illustrated. Price: $11.75.

This book is a monograph in the "American Lectures in Living Chemistry" series and is written by a West Virginia author—Thomas J. Tarnay, M. D., Assistant Professor of Surgery at the West Virginia University School of Medicine.

As stated in the preface, it is prepared specifically for the surgeon and coverage is limited to the true hemophiliac.

The first three chapters are of interest to all physicians who may have any concern about hemorragic illnesses and give a simple understandable account of the general nature of hemophilia and the coagulation factors involved. Anyone would have interest in the brief historical review of information developed throughout the sentences concerning this disease.

Reference is made to the treatment of minor wounds, hematomas and the active treatment and prevention of deformity in hemarthrosis. Major surgery should be reserved for the surgeon who thoroughly understands the coagulation factors of this disease.

Specialty surgical management is given in detail for oral surgery, ENT, urology, orthopedics and neurosurgery.

The finale indicates the future expectations and benefits hopefully to be derived from registration of the hemophiliacs and the role of the voluntary organization, the National Hemophilia Foundation, in treatment of this disease.

In summary, the author concludes that major surgical procedures may now be undertaken in the hemophiliac in a center where adequate laboratory accommodations are available.

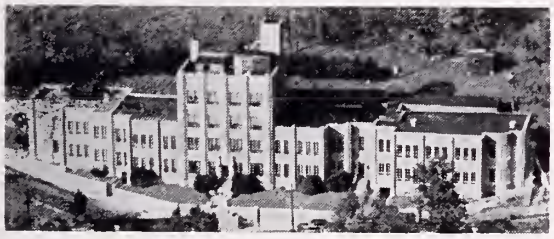
The book is written in an interesting and readable manner and can be of value to physicians in almost any specialty.

* * * *

INSTRUCTIONS FOR PATIENTS—H. Winter Griffith, M. D., Florida State University, Tallahassee. W. B. Saunders Company. Philadelphia.

This book, "Instructions for Patients," is a very large loose-leaf combine of 670 pages, introducing "Directions for Patients" and covering 500 different medical problems in 20 departments of medicine.

The instruction sheet contains general knowledge to help the patient understand his ailment. This information is concise and understandable to the average patient. There are "Important Points in Treatment," a section where medical directions are written in and



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another area, "notify your doctor if any of the following occurs."

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The appropriate sheet is placed in your office copier. Remarks and medication instructions are added to the duplicate. Diet is appended. A drawing to show the location and type of process can be added and the patient now cannot complain of lack of understanding of his illness.

For the common ailments and diets, instruction sheets may be purchased through a publishing source in Florida at a cost of 5¢, which is probably cheaper than processing in our office copying machine.

The book seems to have a real purpose and one wonders why it was so long in coming. There will be many of the notes in the loose-leaf to which you do not have strict adherence, but these can be marked out and your own thoughts added.

The book is large and cumbersome. It doesn't fit on the standard library shelf and is much too big to be left on the desk. If you can overcome these minor handicaps, you will find it useful, practical, precise and timesaving.

Much Blindness Is Needless, National Society Says

Half of all the blind in the nation are victims of a needless tragedy, according to the National Society for the Prevention of Blindness. In addition to those cases due to the neglect in getting an early diagnosis and proper treatment of eye diseases, many are because of accidents.

According to latest data from the Public Health Service's National Health Survey, more than 50 per cent of the accidents causing vision impairment in the United States today occur in the home. This represents a greater number than the combined number of at-work and automobile accidents in which eye injuries are sustained.

This high incidence of home eye injuries is due to carelessness because people just haven't learned to take industry, school and automobile safety habits and attitudes home with them.

To remedy this situation, the Society recommends that all members of the family wear all-purpose safety goggles when mowing lawns (especially with power mowers), burning trash, pruning bushes, spraying plants with insecticides, and while spreading chemical fertilizers. For proper safety goggles for around the home and garden, a local optical equipment center may be consulted.

The Society also warns against throwing glass bottles, used batteries, empty spray cans on trash fires, which

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can cause them to explode, showering potentially-blinding fragments of glass and metal and caustic chemicals.

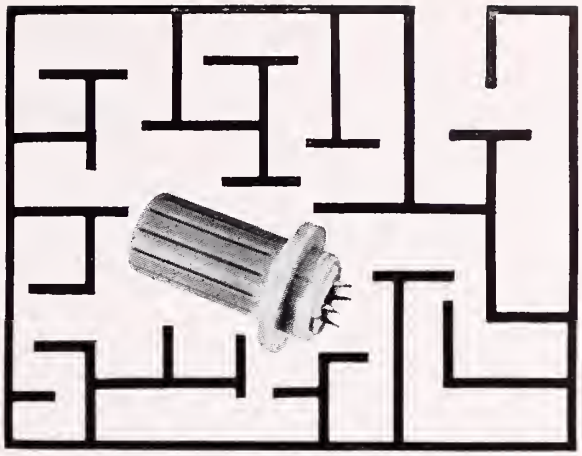
Everyone who wears glasses should wear safety glasses, especially children and senior citizens who are exposed to more and new home-eye-accident hazards.

Little League Baseball recommends that all of their boys who wear glasses should wear safety glasses.

The Society urges parents to keep aerosol sprays containing pressurized liquids, such as deodorants, antibiotics, over cleaners, paints, and hair fixatives out of reach of children at all times. It also warns parents that 17 per cent of the more serious injuries to children's eyes are caused by missile-type toys such as pellet guns, dart guns, air guns, bean shooters, and toys having protruding points and sharp edges.

If we put to full use the scientific and safety knowledge already available, half of all blindness can be prevented. By following these eye-safety recommendations, you and your family can be safer at home.

The National Society for the Prevention of Blindness, Inc., founded in 1908, is the oldest voluntary health agency nationally engaged in the prevention of blindness through a comprehensive program of community services, public and professional education and research.



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AVAILABLE—Board eligible surgeon, 31, married, three children. Filipino, with ECFMG certificate. Will consider any location or hospital. Contact Dr. Ricardo R. Javier, John J. Kane Hosptial, Pittsburgh, Pa.

AVAILABLE—General surgeon upon completion of training in July 1969. Filipino, married, with ECFMG Certificate. Presently doing preceptorship to complete board requirements. Write: Roberto B. De Ocampo, M. D., 40 Prospect Avenue, Norwalk, Connecticut 06850.

WANTED—Eye, Ear, Nose and Throat physician to take over practice of recently deceased physician in Wheeling. Office completely equipped and ready for immediate occupancy. Contact Mr. Joseph M. Follen, 40 12th Street, Wheeling, W. Va. 26003.

AVAILABLE—Urologist, 31, married, two children. University trained and some research experience. Available June, 1969. Will consider any urological position in West Virginia. Write JYC, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Urgent need for a physician to work in a 50-bed hospital in a small and pleasant community near Charleston. Live in or near hospital. Must be licensed in West Virginia. Prefer middle age or older physician in good health. Write DAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

PEDIATRICIANS WANTED—Board or Board Eligible. OEO Rural Health Program. Practice limited to hospital and clinic. Salary $21,000 to $24,000. Fringe benefits. Write Medical Director, Mountaineer Family Health Plan, Inc., Box 1149, Beckley, W. Va. 25801.

WANTED—General practitioner for Cameron, West Virginia. Population 1,700, urban and rural practice. Net income $5,000 per month. Quiet, picturesque town, 20 miles from both Wheeling and Moundsville. Possibility of clinic being built through Sears-Roebuck Foundation. R.N. and L.P.N. available. Excellent prospects. Contact Harry Harpold, Bank Building, Cameron, West Virginia.

EMERGENCY ROOM PHYSICIAN—Accredited 280-bed general hospital. Guaranteed income. Contact Administrator, Cabell Huntington Hospital, 1340 16th Street, Huntington, W. Va.

WANTED—Physician to take over practice of recently deceased physician in Frankford, W. Va. Office completely equipped and ready for immediate occupancy. Contact Mrs. Pearl Foley, Frankford, W. Va. 24938.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Robert D. Hess, Recruitment Committee Chairman, 204 W. Philadelphia Avenue, Bridgeport, W. Va. 26330.

AVAILABLE—Young physician interested in opening in urology upon completion of training in July, 1968. Filipino physician, 33 years old, married and with a ECFMG certificate. Especially interested in the Morgantown area. Write Dr. Buenaventura Seiton, 2720 West 15th Street, Chicago, Illinois 60608.

WANTED—Young physician to take over practice of recently deceased physician. Excellent opportunity in an industrial community in Southern West Virginia. Many advantages. Write CPW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

URGENT NEED—Excellent opportunity for general practitioner. Hospital facilities, office space and housing available. Contact: Sutton General Hospital, Inc., 307 Main Street, Sutton, W. Va. 26601.

WANTED—Excellent opportunity for general practitioner in Glenville, W. Va. Citizens of the community will provide medical facility, local financing and assistance in acquiring housing. Part-time services needed at Glenville State College with equipped infirmary and guaranteed salary. Hospital within 20 miles, new hospital to be constructed 28 miles away. Many recreational facilities available. Contact Mr. Donald L. Fogus, Glenville State College, Glenville, W. Va. Phone 462-8335.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED IMMEDIATELY—A general surgeon for a modern 40-bed well-equipped hospital. We have five general practitioners on the medical staff who do not practice surgery and will refer to a qualified surgeon. Income limited only by desire and ability. Write or call Administrator, Hampshire Memorial Hospital, Romney, W. Va. 26757. Phone 304-822-3514.

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WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

APRIL
1969

Vol. 65 No. 4

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Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1969

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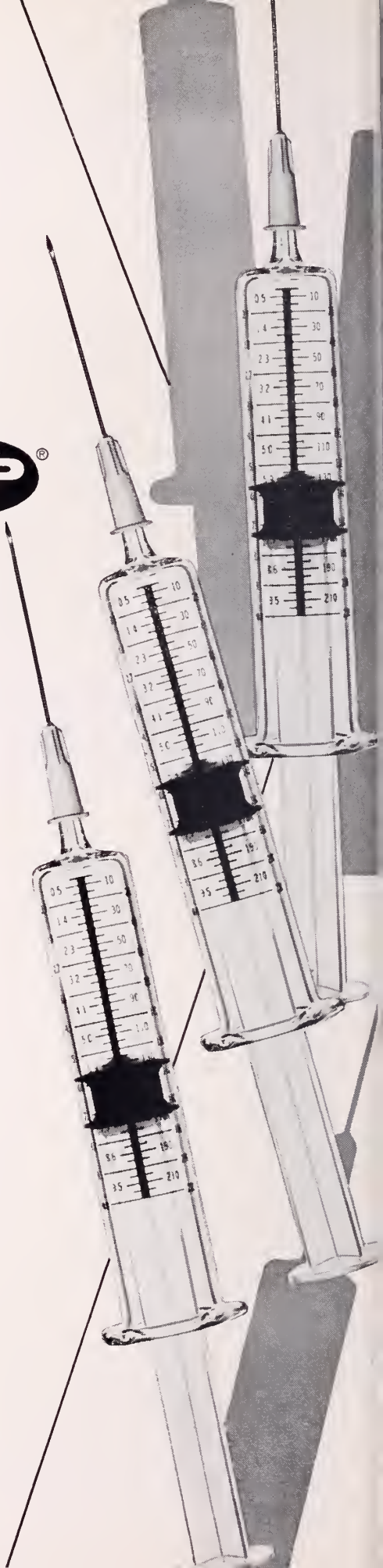

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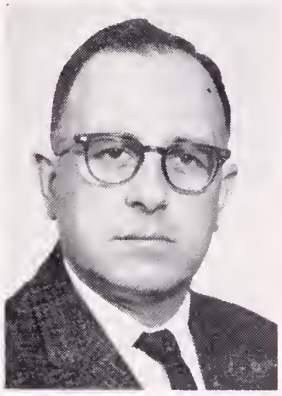
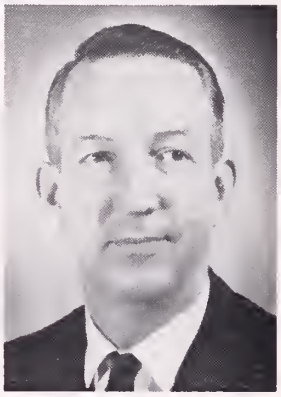
WVU Medical Center
—News—

TWENTY-TWO members of the faculty of the School of Medicine will be advanced in academic rank, effective July 1, according to an announcement by Dr. James G. Harlow, President of WVU.



Allen E. Yeakel, M. D.



David Z. Morgan, M. D.

The following faculty members will be promoted from Associate Professor to Professor:

Dr. Vicente Anido, Pathology; Dr. Robert G. Burrell, Microbiology; Dr. William J. Canady, Biochemistry; Dr. C. H. Joseph Chang, Radiology; Dr. G. Robert Nugent, Surgery; and Dr. Allen Yeakel, Anesthesiology.

Other promotions are as follows:

Assistant Professor to Associate Professor—Dr. Wilbert E. Gladfelter, Physiology and Biophysics; Dr. Ludwig Gutmann, Neurology-Physiology and Biophysics; Dr. Sam Katz, Biochemistry; Dr. George H. Khoury, Pediatrics; Dr. Glen P. McCormick, Speech Pathology and Audiology; Dr. David Z. Morgan, Medicine; and Dr. Robert E. Stitzel, Pharmacology.

Instructor to Assistant Professor—Dr. Kamal Matta Behnam, Obstetrics and Gynecology; Dr. Peter H. Chang, Anesthesiology; Dr. James L. Culberson, Anatomy; Dr. Alexander V. Fakadej, Neurology; Dr. Frances Higginbotham, Anatomy; Dr. William Jacobs, Medicine; Dr. Hisham Majzoub, Surgery; Dr. Arsensio Miranda Orteza, Surgery; Dr. Ralph M. Rogers, Psychiatry; and Dr. William J. Tate III, Medicine.

Doctor Katz Presents Paper

Dr. Sam Katz, Assistant Professor of Biochemistry, presented a paper on February 27 at the 13th Annual Meeting of the Biophysical Society in Los Angeles. The title of his paper was "Conformational Change: Partial Molar Volume Relationship for Native and Denatured Myoglobins and Apomyoglobins."

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

Fifth Annual Cancer Teaching Day

The Fifth Annual Cancer Teaching Day program will be held at the Medical Center, April 18-19. Dr. Alvin L. Watne, Professor of Surgery, is Chairman for the program, which is sponsored by the Medical Center, The Charleston Foundation; the Cancer Committee of the West Virginia State Medical Association; and the West Virginia Division of the American Cancer Society.

Dr. John L. Lewis, Jr., Chief of Gynecology, Memorial Hospital for Cancer and Allied Diseases in New York City, will present the opening lecture on Friday afternoon, April 18, at 4 p. m. His topic will be "The Treatment of Radiation Failure Cancer of the Cervix: Philosophy and Results."

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, will give the welcoming address on Saturday morning. This will be followed by a panel discussion of "The Diagnosis of Carcinoma of the Cervix," to be moderated by Doctor Watne. Panelists and their topics are as follows:

"Epidemiology of Carcinoma of the Cervix"—Antonio Palladino, M. D., Assistant Professor of Obstetrics and Gynecology, WVU.

"The Role of Cytology in the Diagnosis of Carcinoma of the Cervix"—Charles R. Chamberlain, Jr., M. D., Associate Professor of Pathology, WVU.

"Additional Diagnostic Procedures for Carcinoma of the Cervix"—Walter A. Bonney, Jr., Professor and Chairman, Department of Obstetrics and Gynecology, WVU.

"Problems in the Diagnosis of Cervical Carcinoma"—John L. Lewis, Jr., M. D.

The afternoon program will feature a panel on "The Treatment of Carcinoma of the Cervix," to be moderated by Doctor Bonney. Speakers and topics will be as follows:

"The Role of Radiotherapy in Carcinoma of the Cervix"—George G. Green, M. D., Associate Professor of Radiology, WVU.

"The Role of Surgery in Carcinoma of the Cervix"—Doctor Bonney.

"Extended Operations for Carcinoma of the Cervix"—Doctor Palladino.

"Carcinoma of the Cervix and Complicated Conditions"—Kamal M. Behnam, M. D., Instructor in Obstetrics and Gynecology, WVU.

"Treatment of Carcinoma of the Cervix"—Doctor Lewis.

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Ophthalmology:
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M. E. Nugent, M. D.
Richard D. Richmand, M. D.

Ear, Nose & Throat:
W. A. Tiu, M. D.

Orthopedic Surgery:
C. B. Buffingtan, M. D.
E. L. Barrett, M. D.

Thoracic Surgery:
Daniel W. Dickinsan, M. D.

Obstetrics and Gynecology:
Rabert W. Leibald, M. D.
Robert T. Brandfass, M. D.
Hugh R. Haltrop, M. D.

Uralagy:
Richard D. Gill, M. D.
D. C. Trapp, M. D.

Neurological Surgery:
Frank M. Hudsan, M. D.

Dermatology:
H. L. Saferstein, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacab, Jr., M. D.
R. B. Armstrong, M. D.

Psychiatry and Neuralogy:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Raentgenology:
A. K. Butler, M. D.
J. N. Aceta, M. D.

Speech Patholagist and Audialagist:
James P. Frum, M. S.

Clinical Laboratories:
Donna Bryan, M. T.

Technalagists:
Electracardiagraphy:
Betty Maguire, R. N.
Electroencephalagraphy:
Jaann Green, R. N.
Juanita Stone, R. N.
Raentgenalogy:
Evelyn Farester, R. T.

Administration:
Lester L. Cline, Manager
Henry L. Castilaw, Asst. Mgr.

The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association told Congress that the Internal Revenue Service acted arbitrarily and completely ignored the facts in imposing a tax on revenue from drug advertising in journals of tax-exempt medical associations.

Bernard D. Hirsh, AMA General Counsel, testified before the House Ways and Means Committee that the relation between the tax-exempt purposes of a medical association, national or state, and the drug advertising in its journal is self-evident.

"Drug advertising alerts and stimulates the physician's interest in new drugs as they become available, and also serves to remind him of the broad spectrum of useful time-proven drugs," Hirsh said. "Obviously physicians should not and do not rely upon drug advertisements as their principal source of information, but drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs. . . .

"No other advertising provides as much complete and obective information."

Hirsh said the IRS regulations taxing medical associations on their advertising revenues represents an attempt to change the law without congressional action. The IRS officials made a mistake, he said.

"We urge that this mistake be rectified expeditiously and in the most practical way possible," Hirsh said.

Spokesmen for numerous other tax-exempt associations joined the AMA in opposing the tax on their advertising revenues. These included the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Dental Association, the Boy Scouts of America, the Girl Scouts of America, the American Chemical Society and the Society of National Association Publications.

Representatives of commercial publishing firms contended in testimony before the committee that the previous tax exemption gave the journals of the associations an unfair advantage in competition for advertising dollars. When the IRS announced the new tax regulations 15 months ago, it stated that the purpose of the regulations was not to raise federal revenue but to remove a competitive advantage of the tax-exempt associations.

In an announcement not directly connected with the House Committee hearings, the IRS said it also is considering taxing the income tax-exempt associations receive from rental of exhibit and display space at conventions.

Program to Combat Alcoholism

A special advisory committee urged an extensive national program to combat alcoholism. The National Advisory Committee on Alcoholism said in an interim report that attention should be given to alcoholism problems in all federally supported health and welfare programs. The committee also recommended:

Elimination by hospitals of discriminatory policies denying admission to alcoholic patients; health insurance coverage for alcoholics; increased support for research; prevention and control of alcoholism as a vital part of national highway safety programs.

The advisory committee provides advice and guidance to the Secretary of Health, Education and Welfare concerning the Department's activities related to alcoholism. Robert Straus, Ph. D., Professor of Medical Sociology at the University of Kentucky Medical School, is chairman of the committee. It was created in October, 1966. Its members represent all sections of the country and include experts from the fields of medicine, psychiatry, sociology, vocational rehabilitation, law, and public health.

"The magnitude of the problem is enormous," Doctor Straus said. "Our country has more than five million alcoholics. Their suffering alone is intolerable, but the need for increased action is made even more imperative by the fact that affected families may include as many as 20 million Americans."

He also pointed out that alcoholism has a tremendous impact on business, causing absenteeism and loss of productivity.

The National Institute of Mental Health awarded a first-year grant of $250,000 for a major alcoholism research program at the State University of New York, Downstate Medical Center, New York City.

The five-year program will include experimental and clinical studies, training, and drug trials. In one study, 60 newly admitted patients between the ages of 25 and 55 with at least a five-year history of alcoholism will be studied to determine the effects of experimentally induced intoxication and withdrawal on the subjects' sleep patterns, behavior and biochemistry. The investigators will focus upon the mechanisms underlying the development of physical and psychological dependence.

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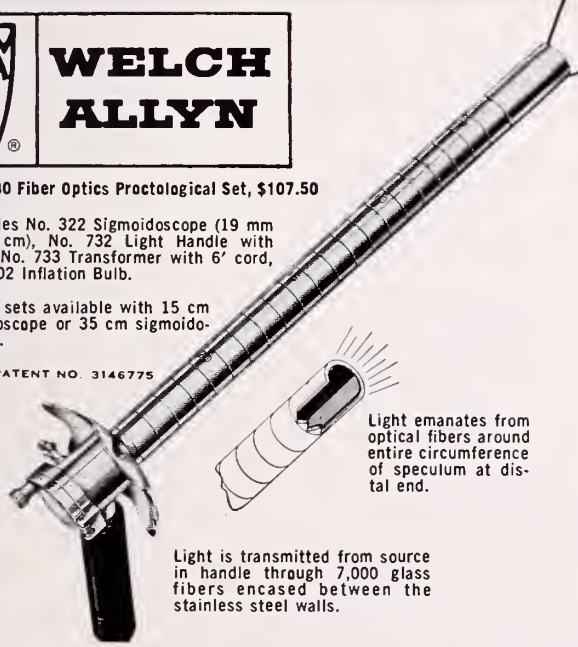
No. 330 Fiber Optics Proctological Set, $107.50

Includes No. 322 Sigmoidoscope (19 mm x 25 cm), No. 732 Light Handle with cord, No. 733 Transformer with 6′ cord, No. 302 Inflation Bulb.

Other sets available with 15 cm proctoscope or 35 cm sigmoidoscope.

U.S. PATENT NO. 3146775



Welch Allyn's New

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Procto-Sigmoidoscopes

- Fiber optics light transmission eliminates light carriers—permits unobstructed vision.
- Stainless steel construction throughout.
- Brilliant distal illumination is shadow-free, without color distortion.
- Air-tight, securely hinged, non-fogging window.

Light is transmitted from an external source in the handle through approximately 7,000 optical glass fibers encased between the walls of the stainless steel speculum. Feces cannot obscure illumination. There are no delicate or protruding light carriers.

Obturators and specula are interchangeable. The No. 19 lamp can be replaced in seconds during examination without withdrawing the speculum. The entire instrument may be cleaned with most standard germicidal solutions or by gas sterilization.

Ask us to demonstrate how these new fiber optics procto-sigmoidoscopes simplify examination and treatment.

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Annual Audit, 1968

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1968 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
500 Kanawha Banking & Trust Building
Charleston, West Virginia 25301

West Virginia State Medical Association
Charleston, West Virginia

We have examined the summary statement of cash receipts and disbursements of the West Virginia State Medical Association and the statements of cash receipts and disbursements by funds for the year ended December 31, 1968, and the statement of securities owned at December 31, 1968. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying summary statement of cash receipts and disbursements and the statements of cash receipts and disbursements by funds present fairly the recorded cash transactions of the West Virginia State Medical Association for the year ended December 31, 1968, and securities owned by the Association at December 31, 1968.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
January 25, 1969

SUMMARY STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1968

CASH IN BANK—JANUARY 1, 1968		$ 63,521.10
RECEIPTS		
Dues	$ 99,480.00	
Interest on U. S. Bonds	487.50	
Collection Commission on A.M.A. dues	830.90	
Advertising	30,624.43	
Emblems sold	50.00	
Subscriptions	633.40	
Exhibit space sold	8,512.50	
Dues collected for A.M.A.	83,160.00	
Interest on savings	1,003.58	
Repayments to Medical Scholarship Fund	5,900.00	
Contributions to Medical Scholarship Fund	500.00	
Contributions—other	1,000.00	
Refunds	994.74	
Employee contributions—Employee Benefit Plan	533.55	
Post graduate courses	410.00	
Total Receipts		234,120.60
		297,641.70
DISBURSEMENTS		
General Fund	67,104.78	
Medical Journal Fund	39,327.63	
Convention Fund	14,542.53	
Dues forwarded to A.M.A. or refunded	83,160.00	
Medical Scholarship Fund	8,140.24	
Total Disbursements		212,275.18
CASH IN BANK—DECEMBER 31, 1968		$ 85,366.52

	1-1-68	12-31-68
Cash in Bank—Savings Account	20,691.01	23,694.59
Cash in Bank—Checking Account	42,830 09	61,671.93
	$ 63,521.10	$ 85,366.52

The accompanying letter is an integral part of this statement.

BLUEFIELD SANITARIUM CLINIC

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JAMES P. THOMAS, M. D.

Orthopedic:
R. R. RAUB, M. D.

Neurosurgery:
E. L. GAGE, M. D.
WM. F. HILLIER, M. D.

Urology:
T. B. BAER, M. D.
STEVE J. MISAK, M. D.

Eye, Ear, Nose & Throat:
F. D. WHITE, M. D.

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GRADY McRAE, M. D.
E. M. SPENCER, M. D.

OBSTETRICS & GYNECOLOGY
E. W. McCAULEY, M. D.
CHARLES S. FLYNN, M. D.
FREDERICK T. EDMUNDS, M. D.

INTERNAL MEDICINE
J. R. SHANKLIN, M. D.
KARL E. WEIER, M. D.
H. F. WARDEN, JR., M. D.
C. D. PRUETT, M. D.
R. O. ROGERS, JR., M. D.

PATHOLOGY
DAVID F. BELL, JR., M. D.
JOHN J. BRYAN, M. D.

ROENTGENOLOGY
S. G. DAVIDSON, M. D.

ANESTHESIOLOGY
DAVID H. GATHERUM, M. D.

BUSINESS MANAGER
JAMES L. FOSTER

GENERAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1968

BALANCE—JANUARY 1, 1968		$ 61,773.63
RECEIPTS		
Dues (allocated to General Fund)	$ 83,936.25	
Interest on U. S. Bonds	312.50	
Collection Commission on A.M.A. dues	830.90	
Refunds—miscellaneous	504.03	
Employee contribution—Employee Benefit Plan	533.55	
Contributions	1,000.00	
Post graduate courses	410.00	
Total Receipts		87,527.23
		149,300.86
DISBURSEMENTS		
Salaries	31,623.58	
Office supplies and expense	4,403.58	
Office rent	3,405.00	
Telephone and telegraph	2,164.02	
Postage	1,990.07	
Travel	7,655.41	
Legal and auditing	2,200.88	
Legislative bulletins and expense	101.48	
Payroll taxes	1,266.36	
Mimeographing	675.01	
Expense of Council and Committee meetings	5,735.16	
Miscellaneous expense	472.27	
Employee Benefit plan	3,584.93	
Rural Health Conference	909.82	
Refund of dues	230.00	
Dues and subscriptions	687.21	
Total Disbursements		67,104.78
BALANCE—DECEMBER 31, 1968		$ 82,196.08
Due from Convention Fund	5,847.16	
Due from Medical Journal Fund	21,443.16	
Balance in General Fund checking account	54,905.76	
Fund Balance		$ 82,196.08

The accompanying letter is an integral part of this statement.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1968

BALANCE—JANUARY 1, 1968 (Deficit)		($17,901.32)
RECEIPTS		
Advertising	$ 30,624.43	
Emblems sold	50.00	
Subscriptions	633.40	
Dues (allocated to Journal Fund)	4,352.25	
Refunds and miscellaneous	125.71	
Total Receipts		35,785.79
		17,884.47
DISBURSEMENTS		
Salaries	8,167.00	
Printing	27,703.12	
Engraving	859.71	
Postage	1,223.45	
Office supplies and expense	451.42	
Miscellaneous	922.93	
Total Disbursements		39,327.63
BALANCE—DECEMBER 31, 1968 (Deficit)		($21,443.16)
Due General Fund	$ 21,443.16	

The accompanying letter is an integral part of this statement.

THE HARDING HOSPITAL

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Medical Director

D. L. HANSON
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CONVENTION FUND

Statement of Cash Receipts and Disbursements Calendar Year 1968

BALANCE—JANUARY 1, 1968 (Deficit)		($ 3,912.63)
RECEIPTS		
Exhibit space sold	$ 8,512.50	
Dues (allocated to Convention Fund)	3,730.50	
Refunds	365.00	
Total Receipts		12,608.00
		8,695.37
DISBURSEMENTS		
Supplies and labor	6,575.64	
Telephone and telegraph	424.96	
Expense of speakers	5,791.75	
Advance Convention Golf Tournament	250.00	
Miscellaneous	500.18	
Auxiliary Convention Expense	1,000.00	
Total Disbursements		14,542.53
BALANCE—DECEMBER 31, 1968 (Deficit)		($ 5,847.16)
Due General Fund	$ 5,847.16	

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Cash Receipts and Disbursements Calendar Year 1968

BALANCE—JANUARY 1, 1968		$ -0-
RECEIPTS		
Dues collected for A.M.A.		83,160.00
DISBURSEMENTS		
Dues forwarded to A.M.A.	$83,090.00	
Dues refunded	70.00	
Total Disbursements		83,160.00
BALANCE DUE A.M.A.—DECEMBER 31, 1968		$ -0-

The accompanying letter is an integral part of this statement.

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements Calendar Year 1968

BALANCE—JANUARY 1, 1968		$ 23,561.42
RECEIPTS		
Dues (allocated to Medical Scholarship Fund)	$ 7,461.00	
Contributions	500.00	
Interest on savings account	1,003.58	
Interest on U. S. Treasury Bonds	175.00	
Repayments of scholarships	5,900.00	
Total Receipts		15,039.58
		38,601.00
DISBURSEMENTS		
Scholarship installment	8,000.00	
Travel printing and miscellaneous expense	140.24	
Total Disbursements		8,140.24
BALANCE—DECEMBER 31, 1968		$ 30,460.76
Balance in Savings Account	23,694.59	
Balance in General Fund Checking Account	6,766.17	
Fund Balance	$ 30,460.76	

The accompanying letter is an integral part of this statement.

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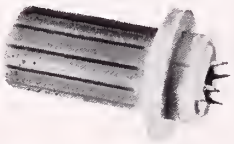

TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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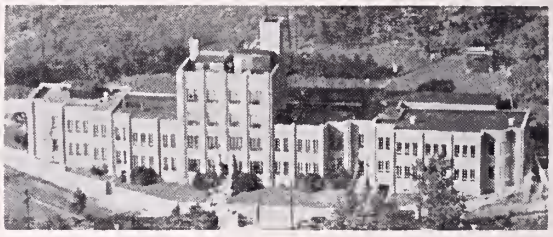

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KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
DONALD F. MANGER, M. D.

Anesthesiology:
G. E. HARTLE, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Brooddus Hospital Resident Staff:
T. H. CHANG, M. D.
MARIO M. ROSALES, M. D.
CLYDE A. BURGESS, M. D.

THE MYERS CLINIC
Philippi, West Virginia

SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1968

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27846F	12-15-67-72	$10,000.00
U. S. Treasury 2½%	70011A	12-15-67-72	1,000.00
U. S. Treasury 2½%	70012A	12-15-67-72	1,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	72361A	12-15-67-72	1,000.00
U. S. Treasury 2½%	22646F	12-15-67-72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67-72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67-72	1,000.00
Series "J"	Q22297J	1- 1-68	25.00
Series "J"	Q22298J	1- 1-68	25.00
Total			$19,550.00

COMPARATIVE SCHEDULE OF FUND BALANCES AND BONDS AS OF DECEMBER 31, 1967 AND 1968

	12-31-67	12-31-68	Increase (Decrease)
FUND BALANCES			
General Fund	$61,773.63	$ 82,196.08	$20,422.45
Medical Journal Fund (deficit)	(17,901.32)	(21,443.16)	(3,541.84)
Convention Fund (deficit)	(3,912.63)	(5,847.16)	(1,934.53)
A. M. A. dues	—	—	—
Medical Scholarship Fund	23,561.42	30,460.76	6,899.34
Total Fund Balances	63,521.10	85,366.52	21,845.42
U. S. BONDS (at cost)	18,621.92	18,621.92	—
TOTAL FUND BALANCES AND BONDS	$82,143.02	$103,988.44	$21,845.42

The accompanying letter is an integral part of this statement.

Three New Volumes Are Issued In AHA Series

Three new volumes have been issued in the American Heart Association's Monograph Series.

They are: "Cardiovascular Surgery 1967," a "Cooperative Study on Cardiac Catheterization" and a "Diagrammatic Portrayal of Variations in Cardiac Structure," reprinted as Numbers 19, 20 and 21 respectively in the series.

"Cardiovascular Surgery 1967," consists of papers presented at AHA's annual Scientific Sessions that year. Edited by Dr. Frederick Kittle, the 230-page, paper cover volume contains 31 articles on various aspects of cardiovascular surgery.

The "Cooperative Study on Cardiac Catheterization" assesses the risk of various procedures, provides data to allow reduction of these hazards, and appraises current procedures in use at catheterization laboratories. Edited by Drs. Eugene Braunwald and Harold J. C. Swan, the material was collected by 16 participating laboratories over a two-year period.

Volume 21 is a system of loose leaf diagrams portraying various types of cardiac structure. It is designed as a unique teaching device to clarify variations on intrinsic cardiac structure, variations in relationships between the great arteries and the ventricles, and the significance of a right-sided cardiac apex. The material was compiled by Drs. Paul Stranger, Robert C. Benassi, Michael E. Korns, Kenneth L. Jue and Jesse E. Edwards.

The volumes may be obtained through local Heart Associations or the AHA National Office, 44 East 23rd Street, New York, N. Y. 10010.

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HUNTINGTON, WEST VIRGINIA

Obituaries

JAY BIGELOW BAILEY, M. D.

Dr. J. B. Bailey of the McDowell County community of Davy died at his home on February 7. He was 63.

Doctor Bailey received his M. D. degree in 1931 from the Medical College of Virginia and was a coal company physician for many years. He was a former member of the West Virginia State Medical Association.

Survivors include the widow, Mrs. Genevieve Clubb Bailey; one daughter, Mrs. Earl Clark of Bucyrus, Ohio; one sister; and five brothers.

* * * *

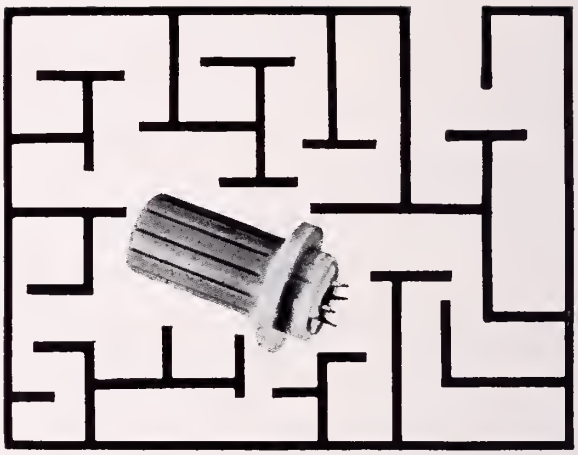
CLAUDE A. THOMAS, M. D.

Dr. Claude A. Thomas of Martinsburg died in a hospital in that city on January 19 at the age of 83.

He was born in Shinnston and received his M. D. degree from Maryland Medical College in 1912. He was a former Health Officer for Berkeley, Lewis and Hampshire counties.

Doctor Thomas was a former member of the West Virginia State Medical Association.

He leaves his widow, Mrs. Myrtle Baker Thomas; five children, James V. Thomas of Arlington, Virginia, Mrs. Dorothy Gillam of Philadelphia, Pennsylvania, Mrs. June Sullivan of Pensacola, Florida, Pat Thomas of Martinsburg, and Mrs. Mary Ella Brinkley of Fort Worth, Texas; and 10 grandchildren.



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HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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OBITUARIES—(Continued)

HAROLD GLYNN YOUNG, M. D.

Dr. Harold G. Young, 67, a veteran of 31 years of service in the Medical Corps of the U. S. Navy, died in a Morgantown hospital on February 23.

Doctor Young entered private practice of surgery in Morgantown in 1958 following his retirement from the Navy with the rank of Rear Admiral. During World War II, he served in both the Atlantic and Pacific areas, and at other times during his military career he was Commanding Officer of the U. S. Naval Hospitals at St. Albans, New York, and at Corpus Christi, Texas.

A native of Moundsville, Doctor Young attended West Virginia University and received his M. D. degree from Northwestern University Medical School in 1927. He was a Diplomate of the American Board of Surgery and was a Fellow of the American College of Surgeons.

Doctor Young was an honorary member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ruth B. Young; a daughter, Mrs. Claire Young Henn of Morgantown; a brother, James Young of Penelope Park, Florida; two sisters, Mrs. Virginia Eskew of Penelope Park, and Mrs. Mary East of Flushing, Ohio; and three grandchildren.

County Societies

MERCER

Dr. William M. Bruch of Bluefield presented the scientific program at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on January 27.

Doctor Bruch discussed the case of a boy with acute lymphatic leukemia in remission following treatment with antimetabolites.

The Society adopted a resolution on the "black lung" controversy which endorsed a statement on the subject adopted by the Council of the State Medical Association at its January meeting.

Dr. Clark K. Sleeth of Morgantown, Dean of the West Virginia University School of Medicine, was guest speaker at the Mercer County Medical Society's February 17 meeting at the West Virginian Hotel in Bluefield.

Doctor Sleeth discussed the development of the School of Medicine and the problems related to faculty recruitment, financing and student selection.—John J. Mahood, M. D., Secretary.

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Edward E. Cale, M. D.
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Don L. Weston, M. D.
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W. E. Wilkinson, M. D.

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Professional Building, Wise, Va
Pierce D Nelson, M. D

MONONGALIA

Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Monongalia County Medical Society, which was held in Morgantown on February 4.

Doctor Corbitt discussed with about 36 Society members in attendance various activities of organized medicine on both state and national levels.

The Nominating Committee presented the name of Dr. James Hugh Wiley for consideration for the office of Vice President of the Society. The report was approved, and Doctor Wiley was elected.—W. Gene Klingberg, M. D., Secretary.

Arthritis Affects 16 Million U. S. Residents

More than 16 million people in the United States awake daily to the chronic aches and pains of arthritis, says the Health Insurance Institute.

And it's costing the 16.8 million arthritics $1 billion annually to treat the disease through drugs, physical therapy, physician services and home care.

The cost of arthritis to the nation as a whole, including annual wage losses and medical care costs, is estimated at more than $3.5 billion annually.

The total national investment in arthritis research and training for this year alone is expected to be $15 million.

There is no known cure for the disease yet—although encouraging developments in its treatment were reported at the recent annual meeting of the Arthritis Foundation in New York.

The U. S. Public Health Service found that in 1966-67, 700,000 Americans were so severely arthritic that they were unable to carry on normal daily activity.

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WANTED—Eye, Ear, Nose and Throat physician to take over practice of recently deceased physician in Wheeling. Office completely equipped and ready for immediate occupancy. Contact Mr. Joseph M. Follen, 40 12th Street, Wheeling, W. Va. 26003.

AVAILABLE—Urologist, 31, married, two children. University trained and some research experience. Available June, 1969. Will consider any urological position in West Virginia. Write JYC, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Urgent need for a physician to work in a 50-bed hospital in a small and pleasant community near Charleston. Live in or near hospital. Must be licensed in West Virginia. Prefer m ddle age or older physician in good health. Write DAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

PEDIATRICIANS WANTED—Board or Board Eligible. OEO Rural Health Program. Practice limited to hospital and clinic. Salary $21,000 to $24,000. Fringe benefits. Write Medical Director, Mountaineer Family Health Plan, Inc., Box 1149, Beckley, W. Va. 25801.

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MAY
1969

Vol. 65 No. 5

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Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston, W. Va. 25324

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Member 1969

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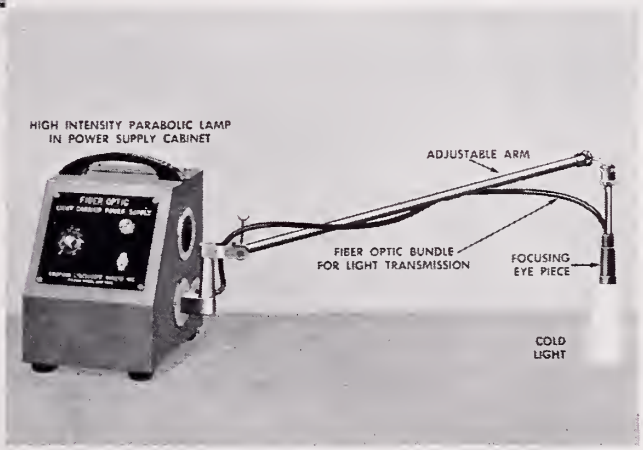

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WVU Medical Center
—News—

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

THE 53 men and three women who will receive their M. D. degrees from the West Virginia University School of Medicine on May 18 have received their internship assignments.

Results of the National Internship Matching Program indicated that 44 of the WVU students received their first choice, and nine others got their second choice. Four will intern in military hospitals, and 52 will receive their graduate training at 29 hospitals in 17 states, including West Virginia. Internships will begin on July 1.

The class members, their hometowns and the hospitals to which they will be assigned are as follows:

Paul V. Akers, Huntington, Cincinnati (Ohio) General Hospital; Harry J. Anderson, Wheeling, and Charles R. Bauer, New York City, St. Louis (Missouri) Children's Hospital; James D. Bobbitt, Huntington, Akron (Ohio) City Hospital; Harold E. Bondy, Fairmont, WVU Hospital; John E. Boso, Huntington, Akron (Ohio) City Hospital; Louis H. Brandstetter, Roanoke, Virginia, Roanoke Memorial Hospital; James L. Brooks III, Mt. Morris, Pennsylvania, Mercy Hospital, Pittsburgh; Jack S. Burks, Charleston, Cincinnati (Ohio) General Hospital.

Steleanos N. Caritis, Weirton, and Roy G. Carter, Northampton, England, WVU Hospital; James R. Castle, St. Albans, Charlotte (North Carolina) Memorial Hospital; Ross L. Cline, Petersburg, Cincinnati (Ohio) General Hospital; Creel S. Cornwell, Jr., Lost Creek, Akron (Ohio) City Hospital; Robert J. Fagioletti, Grindstone, Pennsylvania, Washington (Pennsylvania) Hospital; Robert B. Gainer, Clarksburg, Akron (Ohio) City Hospital; Emanuel Gaziano, Pemberton, Hennepin County General Hospital, Minneapolis, Minnesota; Joseph P. Giffin, Keyser, St. Vincent's Hospital and Medical Center, New York City.

Braden E. Griffin, St. Marys, Children's Hospital, Denver, Colorado; Juan F. Gutierrez, Birmingham, Alabama, WVU Hospital; Theodore P. Haddox, Huntington, Charlotte (North Carolina) Memorial Hospital; William L. Hall, Morgantown, and Paul E. Harvey, Coolspring, Pennsylvania, Washington (Pennsylvania) Hospital; Richard A. Hawkins, Charleston, Community Hospital of Roanoke (Virginia) Valley; Ronald E. Hinebaugh, Monongahela, Pennsylvania, Washington (Pennsylvania) Hospital; Thomas R. Hobbs, Waymart, Pennsylvania, Harrisburg (Pennsylvania) Polyclinic Hospital; David A. Kappel, New Martinsville, Swedish Hospital Medical Center, Seattle, Washington.

Henry L. Kettler, Wheeling, Hartford (Connecticut) Hospital; Mary Frances Knapp, Nitro, Cincinnati (Ohio) General Hospital; Dennis S. Long, Pittsburgh, Pennsylvania, Boston (Massachusetts) University—Boston City Hospital Guidance Center; Robert M. Mace, Cowen, Ohio Valley General Hospital, Wheeling; Vincent J. Mazzella, South Charleston, Charlotte (North Carolina) Memorial Hospital; Michael J. McGinnis, Huntington, WVU Hospital; Michael D. McNeer, Hinton, Memorial Hospital, Charleston; John O. Meadows, St. Albans, North Carolina Baptist Hospitals, Winston-Salem; Daniel E. Michel, Morgantown, Akron (Ohio) City Hospital.

Lawrence R. Morris, Fairbanks, Alaska, U. S. Naval Hospital, Chelsea, Massachusetts; William L. Mossburg, Westover, Madigan General Hospital, Fort Lewis, Washington; Donald L. Naegele, Wheeling, Wheeling Hospital; Robert C. Nerhood, Charles Town, Harrisburg (Pennsylvania) Polyclinic Hospital; Roger P. Nichols, St. Albans, Grady Memorial Hospital, Atlanta, Georgia; Donald M. Null, Jr., Hatboro, Pennsylvania, Wilford Hall USAF Hospital, San Antonio, Texas; Elliot R. Oaklander, Parkersburg, Grant Hospital, Columbus, Ohio; Richard J. O'Brien Jr., Wheeling, University Hospital, Baltimore, Maryland; Raymond E. Pierce Jr., Warrington, Pennsylvania, University of Kentucky College of Medicine, Department of Community Medicine, Lexington; James E. Richardson, North Salem, Indiana, Washington (Pennsylvania) Hospital.

Buford E. Rowe, Richwood, Roanoke (Virginia) Memorial Hospital; Jeffrey N. Seltz, Elkins, Good Samaritan Hospital, Phoenix, Arizona; Lawrence W. Shivertaker, Nitro, Meadowbrook Hospital, East Meadow, New York; Richard G. Stevenson, Morgantown, Washington (Pennsylvania) Hospital; Patricia Stewart, Buffalo, New York, University Hospital Medical Center, Salt Lake City, Utah; Jonathan R. Tatomer, Charleston, Washington (Pennsylvania) Hospital; Arthur J. Weinstein, Lawrence, New York, University Hospital, Seattle, Washington; Leonard Wistrop, Mount Vernon, New York, Montefiore Hospital, Pittsburgh, Pennsylvania; Margaret S. Wells, Keyser, WVU Hospital; and James R. Young, Charleston, Brooke General Hospital, San Antonio, Texas.

Alpha Omega Alpha Lecture

Dr. Theodore Cooper, Director of the National Heart Institute, delivered the annual Alpha Omega Alpha Lecture in the main auditorium of the Medical Center on Friday, April 11.

His subject was "Cardiac Transplantation—Its Place and Its Promise."

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Department of Health, Education and Welfare issued proposed regulations setting standards for rubella vaccine, making it possible it will be ready for distribution in limited quantities by about June 1.

The standards cover production methods, safety, purity and potency. They were developed by the Division of Biologics Standards, a unit of the National Institutes of Health. Final regulations could be published as early as May 3. Indications were that two manufacturers would have a vaccine ready for initial distribution soon after the regulations had been made final.

"This means that we are one step closer to the prevention of a disease that has caused an untold number of tragic births," HEW Secretary Robert H. Finch said when the proposed regulations were issued.

"We are moving ahead to combat German measles in the quickest manner consistent with public safety."

The regulations apply to vaccines containing a live virus strain known as HPV-77, which is grown in either duck embryo or dog kidney cell culture system. Experimental vaccines produced in accordance with the standards have undergone extensive community testing in the United States and abroad. Two manufacturers, Merck, Sharpe & Dohme and Philips Roxane Laboratories have produced vaccines based on this strain.

"We hope that more than one vaccine will be available," Dr. Robert Q. Marston, NIH Director, said. "Regulations covering the use of other virus strains and culture media for rubella vaccine production will be formulated on the basis of extensive tests now going on."

Smith, Kline & French Laboratories has tested widely an experimental vaccine containing the Cendehill strain of rubella virus.

An HEW announcement said:

"German measles is a threat to susceptible pregnant women at any time, but the threat increases significantly during epidemic years. One of the most tragic and disastrous epidemics to hit the United States in modern times was the German measles epidemic of 1964-65. This resulted in about 50,000 abnormal pregnancies. About 20,000 infants were born with such crippling defects as mental retardation, heart disease, blindness and deafness. The remaining 30,000 pregnancies terminated in miscarriage or stillbirth.

Antibiotic Marketing Hit By FDA

The Food and Drug Administration has taken the first step to halt the marketing of 78 antibiotic combination products.

The ultimate action was recommended by the National Academy of Sciences-National Research Council, which is evaluating the effectiveness of about 3,600 new drugs marketed from 1938 to 1962.

Generally, the 78 products were found ineffective as fixed combinations for claims made in their labeling. The FDA emphasized that this does not necessarily mean that either the antibiotics or other active ingredients of the products are ineffective when used alone.

"But the use of two or more active ingredients in the treatment of a patient who can be cured by one is irrational therapy," said Herbert L. Ley, Jr., M.D., Commissioner of Food and Drugs. "It exposes the patient to an unnecessary risk. Antibiotics should be used like a rifle rather than a shotgun."

The majority of the 78 products are antibiotic-sulfa combinations in tablet, capsule, or liquid form. Also included are 16 penicillin-streptomycin combinations that are given by injection.

Other antibiotics used in the preparations include erythromycin, neomycin, tetracycline, chlortetracycline, nystatin, oxytetracycline, oleoandomycin and triacetyloleandomycin. In addition, some of the preparations contain analgesics, vitamins, or other ingredients.

The antibiotics combinations are the products of 21 different manufacturers, including Chas. Pfizer & Co.; Eli Lilly & Co.; Lederle Laboratories division of American Cyanamid Co.; Bristol Laboratories Inc., a division of Bristol-Myers Co.; Merck & Co.; E. R. Squibb & Sons Inc., a subsidiary of Squibb Beech-Nut Inc.; Upjohn Co.; Wyeth Laboratories Inc., a subsidiary of American Home Products Corp.; Abbott Laboratories; and Hoffman-La Roche Inc. In an earlier proposal last December, the FDA similarly moved against products marketed by Squibb, Lederle and Upjohn.

Many of the affected products have been promoted widely and found wide acceptance in the medical profession. Several of the manufacturers promptly said they would contest the FDA ruling and others were expected to oppose it also. The manufacturers were given 30 days to submit any new data on efficacy of the products.

There were 12 products in the first groups, announced last December. A decision still was pending on whether manufacturers of those products should have additional time to submit evidence of efficacy.

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Obituaries

HARRY DIXON LAW, M.D.

Dr. Harry D. Law of Charleston, a retired otolaryngologist, died in a hospital in that city on April 13. He was 81.

Doctor Law was born in the Gilmer County community of Troy and received his M.D. degree in 1917 from the Medical College of Virginia. He was engaged in general practice in Nitro for a time before beginning eye, ear, nose and throat practice in Charleston in 1929. He retired in 1961.

He was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Pearl Law; two daughters, Marjorie and Helen of Charleston; brothers, Park L. Law of Asheville, North Carolina, and Darrell law of Maryland; and sisters, Mrs. Lona Woodford of Glenville and Mrs. Lucy Adams of Jane Lew.

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County Societies

McDOWELL

Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the McDowell County Medical Society, which was held on March 12 at the Stevens Clinic Hospital in Welch.

Doctor Corbitt gave an interesting talk on "The Prospects of Medicine in the State."

Twelve members and six guests attended the meeting.—J. C. Ray, M. D., Secretary.

* * * *

MERCER

Dr. D. Alene Blake of Beckley was guest speaker at the regular monthly meeting of the Mercer County Medical Society, which was held on March 16 at the West Virginian Hotel in Bluefield.

Doctor Blake gave a very interesting talk on "Emotional Problems of Childhood." She discussed personality disorders, psychotic disorders, mental retardation and children with brain damage.

Dr. Frank J. Holroyd of Princeton, Chairman of the State Medical Association's Legislative Committee, reported on bills affecting medicine which were passed during the recent session of the State Legislature.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Ralph R. Landes of the Danville Urologic Clinic in Danville, Virginia, was guest speaker at the regular monthly meeting of the Monongalia County Medical Society, which was held on March 4 in Morgantown.

Doctor Landes presented an interesting paper on "Antibiotic Therapy in Geriatric Urology."

During the business meeting, Dr. John F. Kelley of the Department of Psychiatry at the West Virginia University Medical Center, and Dr. N. LeRoy Lapp

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of the Department of Internal Medicine, WVU, were admitted to membrship in the Society.

The Society decided to contribute $80 to the Easter Seal organization to sponsor one crippled child at Camp Horseshoe.—W. Gene Klingberg, M. D., Secretary.

* * * *

RALEIGH

Lt. Col. Asa Barnes, Jr., was guest speaker at the regular monthly meeting of the Raleigh County Medical Society, which was held on March 20 at Henry's Drive-Inn Restaurant in Beckley.

Doctor Barnes is the son of Dr. Asa Barnes, Sr., of Beckley. Speaking on "The Blood Program in Vietnam," Doctor Barnes, who is assigned to the Armed Forces Institute of Pathology in Washington, discussed conventional and newer methods of blood supply and the treatment and diagnosis of bleeding diathesis that exist with multiple wounds.

During the business session, the Society admitted Dr. Jose G. Alfonso to regular membership and voted to sponsor a diabetic child at Camp Kno-Koma.—John M. Daniel, M. D., Secretary.

Lowest Doctor Draft in Years

The Defense Department will call up 437 medical doctors and 23 osteopaths in 1969 in the lowest doctor draft in years, according to the AMA Washington Office.

Health Insurance Books List Is Published

The 1969 edition of the booklet, "A List of Worthwhile Life and Health Insurance Books" has been published jointly by the Institute of Life Insurance and the Health Insurance Institute for use by librarians, educators, students, researchers, and insurance personnel.

The 80-page publication is an authoritative reference guide to current writings on personal insurance. It includes 495 book titles and a list of 30 periodicals.

Divided into 15 major sections, the booklet covers the uses of life and health insurance by individuals, groups, businesses and professional persons. There are also reference lists of textbooks and materials about careers in the insurance business.

Items of special interest to the management of insurance companies are contained in sections on accounting, investments, actuarial mathematics, advertising, estate planning, gerontology, Social Security and Medicare.

Single copies of the booklet are available at 25 cents each from either the Institute of Life Insurance or the Health Insurance Institute. Both organizations are at 277 Park Avenue, New York, New York 10017.

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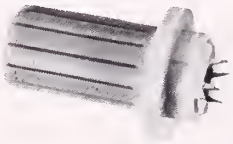

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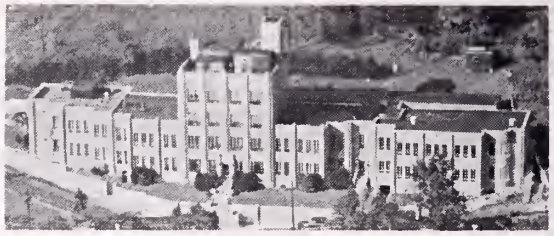

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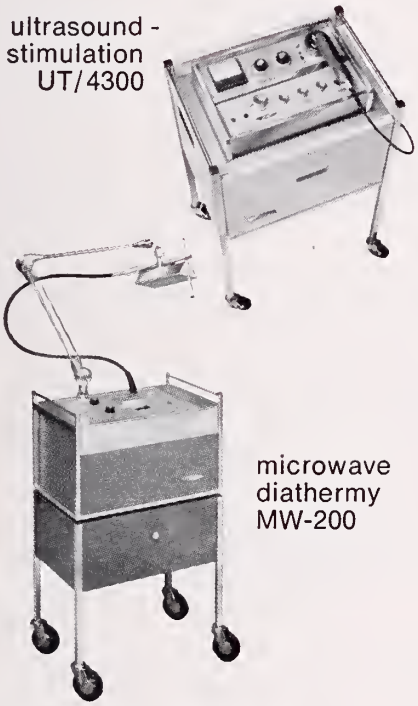

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HARRISON

Mrs. Joe N. Jarrett of Oak Hill, President Elect of the Woman's Auxiliary to the West Virginia State Medical Association, was guest of honor at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society on April 3. The meeting was held at the Stonewall Jackson Hotel in Clarksburg with 36 persons in attendance.

Mrs. L. Dale Simmons of Clarksburg spoke on "You Are What You Eat." She discussed the relationship of calories to body functions, diets and diet aids, and the causes of overweight.

Mrs. Robert S. Wilson of Clarksburg, President, presided at the business session.—Mrs. Robert D. Hess, Publicity Chairman.

* * * *

KANAWHA

Mrs. Sue Boe of Washington, D. C., was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society, which was held on March 11 in Charleston.

Mrs. Boe is consumer information specialist for the Pharmaceutical Manufacturers Association.

She said that prescription drugs are not a consumer item but as much a medical tool as a scalpel. She discussed various aspects and problems of the drug industry, including generic versus brand name prescription of drugs.

* * * *

McDOWELL

The Woman's Auxiliary to the McDowell County Medical Society held its annual Doctors' Day observance on March 30. A dinner was held at the Gary Country Club.

Mrs. A. B. Carr gave the invocation and the President of the Auxiliary, Mrs. A. A. Carr, welcomed the guests. Dr. J. H. Murry gave the response for the McDowell County Medical Society.

* * * *

MARION

The Woman's Auxiliary to the Marion County Medical Society celebrated Doctors' Day with a dinner party at the Fairmont Field Club. Thirty-eight persons attended.

The welcome was given by Mrs. Kenneth Bailey, President of the Auxiliary, and the response was given

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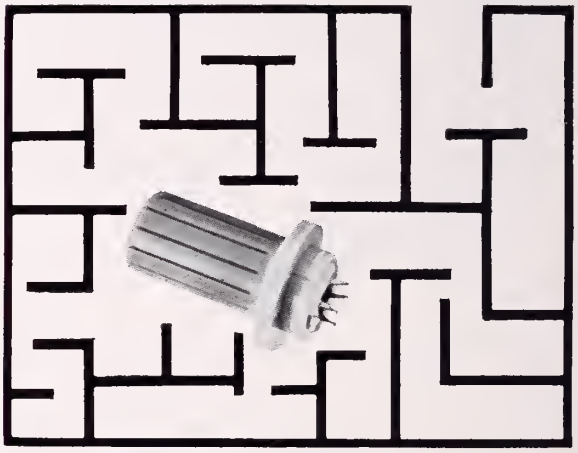
An article on "Assisted Circulation" which discusses the physiological requirements or specifications for mechanical circulatory assistance and outlines some popular methods and their clinical application, has been reprinted by the American Heart Association.

The article, originally carried in *Modern Concepts of Cardiovascular Disease,* is by Drs. Theodore Cooper, then the Associate Director for the Artificial Heart, Myocardial Infarction Program, National Heart Institute, and now Director of the Institute, and Peter J. Dempsey, Research Associate, National Heart Institute.

The section on physiological requirements includes discussions of mechanical support for maintenance of systemic blood flow, reduction of stress on the heart and improvement of myocardial contraction. The section on popular methods covers veno-arterial pumping, left heart bypass, arterial pumping and intra-aortic balloon pumping.

Copies of the reprint may be obtained from local Heart Associations or the American Heart Association National Office, 44 E. 2rd Street, New York, New York 10010.



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1969 Group Insurance Forum In Philadelphia

The reorganization of present methods of hospital care and treatment of patients was called for in a panel discussion at the 1969 Group Insurance Forum sponsored by the Health Insurance Association of America.

The Forum was held in Philadelphia in February.

One of the more effective ways the health insurance business can help in this regard is to become involved in planning activities, said Jerome Pollack, Associate Dean for Medical Care Planning at Harvard Medical School.

"We are greatly in arrears in planning," he told the Forum. "Bold planning is imperative. We must start to do something about it."

Mr. Pollack said it is too expensive for the average hospital—which has an occupancy rate of 76 per cent—to have one fifth of its beds vacant.

Other panel members were Lawrence E. Martin, associate director and comptroller of the Massachusetts General Hospital; and Dr. George Dunlop, a surgeon from Worcester, Massachusetts.

The satellite concept is becoming established as cases are being sent from surrounding community hospitals to a centrally located hospital involved with acute, more expensive cases, Mr. Martin said.

"Hospitals no longer can generate income through ancillary charges," he said. "Income must come from the room and board charges."

Planning is going in the wrong direction," Mr. Martin noted. "Although we have concentrated on stopping duplication of services, I would be more comfortable if they devised a new concept of distribution of care."

Hospital outpatient clinics must provide low cost ambulatory care—something they have not been able to do as traditionally defined, according to Doctor Dunlop.

These clinics—many of them new, but with outdated treatment methods—have not been the result of sound planning, he said.

Doctor Dunlop cited the need for hospitals to "compete" with each other in order to lower costs and improve treatment.

"We need to put competition into action," he said. "We have had very little competition in performance as related to costs."

He said physicians must keep up with medical advancements through the available facilities or the government will move in and possibly ask for their recertification.

Although the physician has long resisted the "team approach" as the answer to more effective medical care, Doctor Dunlop said the physician knows the difficulties in one person carrying out all the procedures and now realize this approach is needed.

He questioned whether group practice—the closed panel type when MDs are salaried—has the wide applicability as has been suggested.

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AVAILABLE—Board eligible surgeon, 31, married, one child. Will complete training June 30, 1969, and will consider any general surgery position in West Virginia. Currently serving as chief resident at a university hospital. Write GDD, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Board eligible general surgeon upon completion of training on June 30, 1969. Filipino, married, with ECFMG Certificate. Presently Chief Resident, finishing the fourth and final year of training in a Type I residency program. Write: Rafael E. Saladar, M. D., Illinois Central Hospital, 5800 Stony Island Ave., Chicago, Illinois 60637.

AVAILABLE—Board eligible surgeon, 31, married, three children. Filipino, with ECFMG certificate. Will consider any location or hospital. Contact Dr. Ricardo R. Javier, John J. Kane Hosptial, Pittsburgh, Pa.

AVAILABLE—General surgeon upon completion of training in July 1969. Filipino, married, with ECFMG Certificate. Presently doing preceptorship to complete board requirements. Write: Roberto B. De Ocampo, M. D., 40 Prospect Avenue, Norwalk, Connecticut 06850.

WANTED—Eye, Ear, Nose and Throat physician to take over practice of recently deceased physician in Wheeling. Office completely equipped and ready for immediate occupancy. Contact Mr. Joseph M. Follen, 40 12th Street, Wheeling, W. Va. 26003.

AVAILABLE—Urologist, 31, married, two children. University trained and some research experience. Available June, 1969. Will consider any urological position in West Virginia. Write JYC, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Urgent need for a physician to work in a 50-bed hospital in a small and pleasant community near Charleston. Live in or near hospital. Must be licensed in West Virginia. Prefer middle age or older physician in good health. Write DAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

PEDIATRICIANS WANTED—Board or Board Eligible. OEO Rural Health Program. Practice limited to hospital and clinic. Salary $21,000 to $24,000. Fringe benefits. Write Medical Director, Mountaineer Family Health Plan, Inc., Box 1149, Beckley, W. Va. 25801.

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WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal. P. O. Box 1031, Charleston, W. Va. 25324.

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JUNE
1969

Vol. 65 No. 6

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Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1969

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References:

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WVU Medical Center
—News—

JAMES M. WADE, a third-year medical student at WVU and his wife, Linda, have been awarded a $3,287 fellowship which will permit them to assist for 12 weeks this summer at a mission hospital in Tanzania, East Africa.

James M. Wade

Wade is the son of Mr. and Mrs. Ralph M. Wade of Princeton. He is one of 31 American Medical Students selected to receive Smith, Kline and French Foreign Fellowships from the Association of American Medical Colleges.

The Wades left for the Kola Ndoto Hospital on May 19. Wade will participate in ward rounds, examinations, surgery and other clinical activities and will also work with leprosy patients. Mrs. Wade, a registered nurse, will teach public health nursing and work with out-patients and leprosy patients.

SAMA Officers Elected

Deleno Webb of St. Marys, who is completing his second year as a medical student, has been elected President of the Medical Center's chapter of the Student American Medical Association. He was a 1967 winner in the State Medical Association's scholarship program.

• **Compiled from materiol furnished by the Medical Center News ond Informotion Services, Morgantown, West Virginia.**

Other officers of the SAMA chapter for 1969-70 are: Richard Herrick of New Martinsville, Vice President; Phillip Peters of Wheeling, Secretary; and Michael Grant of Nitro, Treasurer.

Class representatives are: Creel Cornwell of Lost Creek and Roger Nichols of St. Albans, Medicine IV; Larry Beall of Mannington and Louis Kaufman of Moundsville, Medicine III; Charles Morgan of Pineville and William Hess of Vienna, Medicine I; and Charles Marsh of San Francisco and Evelyn Melnick of Hemphill, Medicine II.

Doctor DeBakey Visits WVU

Dr. Michael E. DeBakey of the Baylor University College of Medicine visited the Medical Center on April 24 during the University's annual "Festival of Ideas" observance. The title of his lecture in the Medical Center auditorium was "Every Man's Responsibility."

Doctor Marshall Speaks Abroad

Dr. Robert J. Marshall, Professor of Medicine and Chairman of the Division of Cardiology, will lecture in England and Ireland this month.

Doctor Marshall will speak at the Royal Postgraduate Medical School in London, at the newly opened Medical School of the University of Nottingham, and at the Institute of Clinical Science, Queen's University of Belfast.

These medical students are new members of the WVU chapter of Alpha Omega Alpha, national medical honorary. Left to right: James R. Castle of St. Albans, Robert Fagioletti of Grindstone, Pennsylvania, Roger Nichols of St. Albans, Patricia Stewart of Buffalo, New York, James Richardson of North Salem, Indiana, Jack Burks of Charleston, and Dennis Long of Pittsburgh, all fourth-year students; and Gary Marcus of Bethlehem, Pennsylvania (President Elect), Sandra Woolfitt of Charleston, and Terrance Steiner of Huntington, all third-year students.

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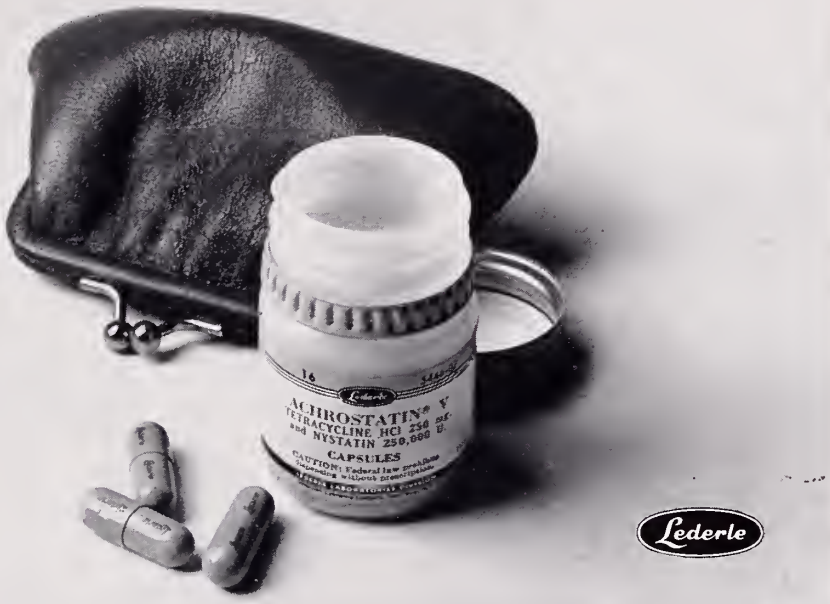

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Richard D. Richmond, M. D.

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Orthopedic Surgery:
C. B. Buffington, M. D.
E. L. Barrett, M. D.

Thorocic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.
D. C. Trapp, M. D.

Neurologicol Surgery:
Frank M. Hudson, M. D.

Dermotology:
H. L. Saferstein, M. D.

Internal Medicine:
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Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.
R. B. Armstrong, M. D.

Psychiatry ond Neurology:
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David H. Smith, M. D.

Roentgenology:
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J. N. Aceto, M. D.

Speech Pothologist ond Audiologist:
James P. Frum, M. S.

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Donna Bryan, M. T.

Technologists:
Electrocardiography:
Betty Maguire, R. N.
Electroencephalography:
Joann Green, R. N.
Juanita Stone, R. N.
Roentgenology:
Evelyn Forester, R. T.

Administrotion:
Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

The Month in Washington

• **From the Washington Office of the American Medical Association.**

HEALTH, Education and Welfare plans to impose Blue Shield schedules for physicians under Medicaid and to limit payments to hospitals under Medicaid and Medicare drew strong responses from the American Medical Association and the American Hospital Association.

Dr. Dwight L. Wilbur, President of the AMA, urged in a letter to Robert H. Finch, HEW Secretary, that all segments of the health care field be consulted in effecting economies in government-paid health services.

"The American Medical Association is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people," Doctor Wilbur said. "The needs and problems of patients in all walks of life, at all income levels, come to their attention, in composite, more than a billion times a year.

"It has always been a principle of both the humanity and the professional code of the physician that no one shall ever be denied quality health care because of his inability to pay. The present concern is how this universal care can best be provided within a viable economic system and in the face of burgeoning demand for medical manpower, services, and facilities . . .

"The knowledge and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem."

Doctor Wilbur wrote Finch following the HEW announcement that federal spending on the Medicaid-Medicare programs would be trimmed by $328 million through imposing Medicaid fee schedules based on prevailing Blue Shield rates, limiting mental illness benefits under Medicaid and cutting down hospital overhead allowances in Medicaid and Medicare.

"It is important to recognize that there are many variables in the circumstances of payment for medical and hospital services," Doctor Wilbur said. "Local needs and resources, the educational and motivational levels of the people, the economic conditions of the state and the community are among the reasons for the differences exhibited by the payment patterns of the Blue Shield plans and health-insurance companies.

"These circumstances must be the foundation for any policies involving cost and payments. No universal pattern—no matter how many variations it may try to provide—can be imposed on the thousands of localities without wreaking havoc and probably increasing inefficiency and costs."

The American Hospital Association protested in a letter to President Nixon against removal of the two percent overhead allowance for hospitals. Officially representing the AHA, Ray R. Eppert of Detroit, hospital trustee, said in a memorandum accompanying the letter to Nixon:

"The recent announcement of a reduction in Medicare reimbursement poses a serious threat to institutional integrity and, therefore, to the ability of hospitals to serve the sick and injured of this nation. Hospitals have been repeatedly assured at the highest levels of government that Medicare changes would not be made without consultation with their designated representative, the American Hospital Association.

"The AHA has tried repeatedly but unsuccessfully to meet with Secretary Finch. It is incredible that the federal government would propose, without any consultation, removal of the two percent allowance which is a proper component of reasonable costs guaranteed under the law as passed by the Congress.

"The department apparently deemed it unnecessary to consult with the hospital field, and, as far as can be determined, made no serious study of the effect of the proposed reduction on hospitals. Payment of nothing but raw costs will lead . . . to the serious underfinancing of our hospitals."

Drug Combinations

Drug combinations became the target of the Senate Small Business Subcommittee's investigation of the prescription drug industry.

Medical school professors critical of drug combinations were called as witnesses in two days of hearings opening this phase of the drug industry probe which began nearly two years ago. It was not indicated when, or even whether, drug company representatives would have an opportunity to defend their combination products before the subcommittee.

Dr. Heinz F. Eichenwald, a National Academy of Science drug specialist, told the subcommittee that "misleading advertising" had lured "the gullible physician" into prescribing useless and sometimes dangerous drug combinations. He also said continued use of drug combinations "amounts to a strong indictment of the ability of many physicians to judge what is effective and what isn't."

PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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Obituaries

CARL CHESTER ROMINE, M. D.

Dr. Carl C. Romine of Morgantown died on April 26 of an apparent heart attack suffered while driving his car in Morgantown. He was 77.

A native of West Milford, Doctor Romine had practiced medicine and surgery in Morgantown since 1927. He received his M. D. Degree in 1919 from the University of Maryland College of Medicine, and he practiced in Clarksburg and in Jenkins, Kentucky, for several years before locating his practice in Morgantown.

The University of Maryland had planned to honor him this month on the 50th anniversary of his graduation.

Doctor Romine was a former Treasurer of the Monongalia County Medical Society. He was also an honorary member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ruby Shaffer Romine; one daughter, Mrs. Rubyan Romine Haden of Wilmington, Delaware; one son, Robert Carl Romine of Aiken, South Carolina; and six grandchildren.

* * * *

RAYMOND A. UPDIKE, M. D.

Dr. Raymond A. Updike, 64, died on April 20 at his home in Montgomery of an apparent heart attack.

A native of the Fayette County community of Kaymoor, Doctor Updike had lived in Montgomery for 55 years. He attended West Virginia Institute of Technology and received his M. D. degree in 1930 from the University of Louisville School of Medicine.

He interned at Louisville City Hospital and did postgraduate work there in internal medicine and psychiatry. During World War II, he served in the Medical Corps of the United States Army and was stationed in India for three years.

Doctor Updike was a member of the Fayette County Medical Society, the West Virginia State Medical Association, the American Medical Association and the American Academy of General Practice. He was a member of the Council of the State Medical Association, 1952-54.

Survivors include the widow, Mrs. Mabel Adams Updike; daughters, Mrs. Don Comuzzi of Allentown, Pennsylvania, and Mrs. Elizabeth Gilson of Morgantown; a son, Raymond Lawrence of Charleston; sisters, Mrs. Harriet Hearst of Clarion, Pennsylvania; and Mrs. Elizabeth Jenkins of Albuquerque, New Mexico; and half-brothers, Dr. Joseph Skaggs of Charleston, and Robert C. Skaggs of Montgomery.

* * * *

HELEN MERWIN WIESTLING, M. D.

Dr. Helen M. Wiestling, 79, Senior Medical Officer for the Veterans Administration Regional Office in Wheeling, died in a hospital in that city on April 28.

Doctor Wiestling was reported to be the Veterans Administration's oldest practicing psychiatrist.

A native of Wheeling, Doctor Wiestling received an A.B. degree in 1911 from West Virginia University. She taught school for several years before enrolling at the Boston University School of Medicine, where she received her M.D. degree in 1926.

For a number of years she was associated with the Massachusetts Department of Mental Health. She returned to Wheeling in 1951.

Doctor Wiestling was a Diplomate of the American Board of Psychiatry and Neurology. She was a member of several specialty organizations in addition to the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Several nieces and nephews survive.

* * * *

WILLIAM E. WILKINSON, M. D.

Dr. William E. Wilkinson, 61, Director of the Beckley Mental Health Center, died in a Beckley hospital on May 5.

Doctor Wilkinson was born in Ridgeville, North Carolina, and received a B.S. degree from Davidson College in 1928. He attended the University of North Carolina and Duke University schools of medicine, receiving his M. D. degree in 1932. He served an internship and two residencies at Duke Hospital.

A Diplomate of the American Board of Neurology and Psychiatry, Doctor Wilkinson served for more than 20 years in the Medical Corps of the United States Army. He was discharged with the rank of Colonel.

(Continued on page XXVI)

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OBITUARIES—(Continued)

He was a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association. His other professional memberships included the American Psychiatric Association and the Southern Medical Association.

Survivors include the widow, Mrs. Mattie Wilkinson; a son, William S. Wilkinson of Fort Bragg, North Carolina; a daughter, Mrs. A. G. Woods of Turley, North Carolina; stepmother, Mrs. Blanche Pinchback of Ridgeville, North Carolina; sisters, Elizabeth of Ridgeville, Miss Dorothy Wilkinson of Durham, North Carolina, Mrs. Elwood Watterfield of Prospect Hill, North Carolina, Mrs. Edith Wilson of Yanceyville, North Carolina; and Mrs. Kathryn Allen of Blanch, North Carolina; and a brother, James C. Wilkinson of Ridgeville.

Heart Association Appoints Field Representative

Mrs. Viola Hutchison of Huntington has been appointed a Field Representative for the West Virginia Heart Association, according to an announcement by Mr. Richard J. Bates. Executive Director of the Association.

Mrs. Hutchison will cover a 21-county area in the western part of the State. She previously was employed at Cabell-Huntington Hospital.

County Societies

LOGAN

Dr. Richard W. Corbitt of Parkersburg was guest speaker at a joint meeting of the Logan County Medical Society and its Woman's Auxiliary at the Woman's Club in Logan on April 23.

Doctor Corbitt, President of the West Virginia State Medical Association, gave an interesting talk on the programs and problems of the State Association.

* * * *

McDOWELL

Dr. W. E. Copenhaver of St. Luke's Hospital in Bluefield was guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at Doctors Memorial Hospital in Welch on April 9.

Doctor Copenhaver discussed child abuse, radiology and cancer. In regard to child abuse, he discussed a case report of subdural hematoma with long-bone fracture.

Seven members and five guests attended the meeting. —J. C. Ray, M. D., Secretary.

* * * *

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Dr. Richard W. Corbitt of Parkersburg, President of

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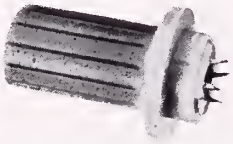

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G. E. HARTLE, M. D.

Dentistry:
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T. H. CHANG, M. D.
MARIO M. ROSALES, M. D.
CLYDE A. BURGESS, M. D.

THE MYERS CLINIC
Philippi, West Virginia

the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on April 21.

Among subjects covered by Doctor Corbitt were "black lung" legislation, third party medicine and Workmen's Compensation.

The Society voted to sponsor a camper at Camp Kno-Koma, the summer camp for diabetic children, and admitted Dr. Albert J. Paine to membership as a transfer from the Cabell County Medical Society.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

The Monongalia County Medical Society held a joint meeting with local dental and lawyer groups in Morgantown on April 1.

Mr. Stanley E. Preiser, Charleston attorney, was guest speaker. He gave an interesting talk on the law of malpractice.

Thirty-one members attended the Medical Society business meeting. The Society voted to sponsor two campers at this year's session of Camp Kno-Koma, the summer camp for diabetic children.—W. Gene Klingberg, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Three members of the Legislature were guests at the regular monthly meeting of the Parkersburg Academy of Medicine which was held at the American Legion Hall in Parkersburg in April.

The guest legislators were Senators Robert W. Burk, Jr., of Parkersburg and Frank Deem of St. Marys and Delegate William Nicely of Parkersburg.

Actions of the 1969 Legislature pertaining to health care were discussed.

* * * *

RALEIGH

Mr. William Gray, representative of the Merrill Lynch Investment Company, was guest speaker at the regular monthly meeting of the Raleigh County Medical Society, which was held at Henry's Drive Inn Restaurant in Beckley on April 17.

Mr. Gray gave an interesting talk on "Investments." A discussion period followed.

Dr. James Barnes was admitted to full membership in the Society.

Fifty members and guests were in attendance.—John M. Daniel, M. D., Secretary.

* * * *

TYGART'S VALLEY

Dr. W. Gene Klingberg of Morgantown was guest speaker at a meeting of the Tygart's Valley Medical Society, which was held at Galloway on April 18.

Doctor Klingberg, Professor and Chairman of the Department of Pediatrics at the West Virginia University Medical Center, gave an interesting talk on intestinal disorders in infants.

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TRUE GLUCOSE: a glucose oxidase determination that is specific for glucose.

HEMOGLOBIN TEST: a Cyanmethemoglobin procedure that is currently in use in most hospital and clinical labs.

CHOLESTEROL TEST: a modified Liebermann-Burchardt procedure for the determination of total cholesterol.

UREA NITROGEN TEST (B. U. N.): a modified Berthelot procedure combining urease with a phenate and hypochlorite indicator.

URIC ACID TEST: is a modified Brown procedure and takes thirty seconds to perform.

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Western Regional Director: Mrs. Joseph E. Ricketts, Huntington
Southern Regional Director: Mrs. J. E. Blaydes, Jr., Bluefield
Treasurer: Mrs. William T. Lawson, Fairmont
Recording Secretary: Mrs. Richard G. Starr, Beckley
Corresponding Secretary: Mrs. James H. Walker, Charleston
Parliamentarian: Mrs. George A. Curry, Morgantown

HARRISON

Mrs. Charles E. Andrews of Morgantown was guest of honor at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society, which was held on May 1 at the Stonewall Jackson Hotel in Clarksburg.

Mrs. Andrews, Eastern Regional Director of the Woman's Auxiliary to the West Virginia State Medical Association, presided at the installation of new officers.

Mrs. Lawrence B. Thursh was installed as President to succeed Mrs. Robert S. Wilson. Other new officers are as follows: Mrs. Karl A. Dillinger, President Elect; Mrs. Robert D. Hess, Vice President; Mrs. William N. Walker, Jr., Secretary; and Mrs. Mehmet V. Kalaycioglu, Treasurer.

Mrs. Kalaycioglu, a native of Istanbul, gave an interesting talk on the differences in the customs and ways of life between Turkey and the United States.—Mrs. Robert D. Hess, Publicity Chairman.

* * * *

LOGAN

Mrs. Joe N. Jarrett of Oak Hill, President Elect of the Woman's Auxiliary to the West Virginia State Medical Association, was guest of honor at the regular monthly meeting of the Woman's Auxiliary to the Logan County Medical Society. The meeting was held on April 11.

Mrs. Jarrett gave a brief report of new programs that could be undertaken by the local Auxiliary. Mrs. J. E. Ricketts of Huntington, a Regional Director of the State Auxiliary, installed new officers. They are as follows:

Mrs. Mark Spurlock, President; Mrs. Thomas P. Long, Vice President; Mrs. Alfredo Crucet, Secretary; and Mrs. Sergio Payuyo, Treasurer.—Mrs. Alfredo Crucet, Secretary.

* * * *

MARION

New officers were installed at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society, which was held at The Fairmont Hotel in Fairmont on April 29.

Mrs. Harry Fleming assumed the presidency, succeeding Mrs. Kenneth Bailey. Other new officers are: Mrs. Harry Lawson, President Elect; Mrs. Reverdy Jones, Vice President; Mrs. John Kramer, Treasurer; and Mrs. Robert Sidow, Recording Secretary.

Mrs. Charles E. Andrews of Morgantown, Eastern Regional Director of the Woman's Auxiliary to the West Virginia State Medical Association, presided at the installation of officers.

After the business meeting, women joined their husbands for a program about Vietnam presented by Dr. Reverdy Jones, who recently returned from that country after a voluntary two-month tour of duty under the Volunteer Physicians for Vietnam Program.

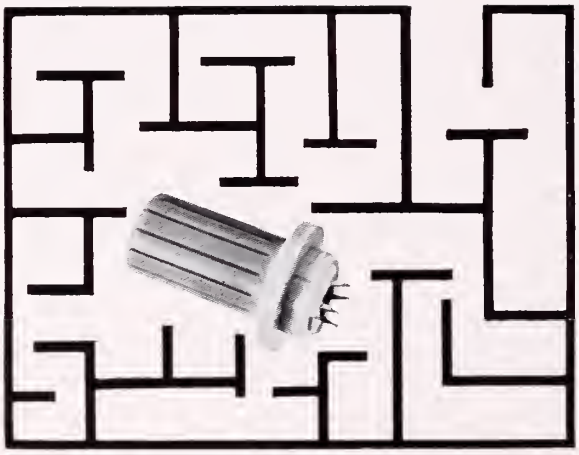
* * * *

MONONGALIA

The regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held in Morgantown in April.

Mrs. Lenette M. Hardin of the University Creative Arts Center Division of Drama did some dramatic readings and discussed the uses of oral interpretation as therapeutic activity for the sick and well alike.

Mrs. John Stecker served as Chairman of the Hostess Committee.



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Change of Address

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Book Reviews

EARLY TEACHERS IN WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE, 1869-1922—This little book was written by our Associate Editor, Dr. Edward J. Van Liere, Ph. D., M. D., Litt. D., Dean Emeritus and Emeritus Professor of Physiology at the West Virginia University School of Medicine.

The book consists of a series of brief biographical sketches, listing the outstanding teachers in medicine from 1869-1922. It is apparent that in 1969 there are few practicing graduates with personal recollection of these early teachers, but the book is a sound contribution to the history of medical education in West Virginia.

The alphabetical order begins with Dr. Benjamin W. Allen, whose tenure lasted from 1882-1887. He was a West Virginia native who was unusually educated for his time. At that time there were only 136 students in the whole university. Dr. Allen became president of the Medical Society of West Virginia in 1883.

Dr. Aaron Arkin was a teacher in bacteriology. He established the State Hygienic Laboratory at the University in 1914. Four years later the Laboratory was moved from the Medical School to Charleston.

Dr. Hugh W. Brock was the first physician to teach at West Virginia University. He was among the group that signed the call for the establishment of a Medical Society in West Virginia. He promoted legislation for the compulsory registration of vital statistics, but his efforts did not bear fruit for 50 years. He also was president of the Medical Society of West Virginia. He must have been a good teacher because his presidential address was one of the most masterly orations in the history of our Association.

Dr. Gideon S. Dodds is remembered by many physicians for many things. During the past 20 years, Doctor Dodds with Doctor Van Liere has been a power house in the interpretation and appraisal of foreign graduates applying to the Medical Licensing Board.

Probably the greatest name in the history of West Virginia Medicine was Dr. Otto Knut Folin, who was

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Professor of Chemistry in the school years of 1899-1900. It is a great regret he did not stay in West Virginia.

Some West Virginia physicians will remember Dr. John W. Simpson, Dean of the West Virginia University Medical School for many years and regarded as "the Father of the Medical School." He was president of the West Virginia State Medical Association in 1923.

We are indebted to Doctor Van Liere for placing these pioneers in proper perspective. The little volume will be enjoyed by most physicians and deserves a permanent place in the medical libraries of the State.—George F. Evans, M. D.

National Blue Shield Admits British Affiliate

The British United Provident Association (BUPA), a private health care financing organization which is thriving amidst the National Health Service system of Great Britain, has become an affiliate member of the National Association of Blue Shield Plans.

The action, which for the first time extends Blue Shield beyond the Atlantic, was taken during the annual business meeting of Blue Shield Plans in Chicago.

The 82 Blue Shield Plans in the United States, Puerto Rico and Canada serve more than 77 million persons, and pay $2.8 billion a year in health care claims.

Despite Great Britain's National Health Service system, there are well over two million British citizens today who are willing to pay their own health care expenses. This is done htrough a variety of private prepayment organizations such as the BUPA.

The British organization was started in 1948 with 80,000 members. In 1968, BUPA had subscription income of $27 million. The organization has built a chain of hospitals to serve their subscribers. The hospitals were financed through BUPA's investment program and the support of members in local communities.

Heart Association Offers Testing Unit

A four panel table-top unit for physicians to test their ability in the diagnosis and treatment of arrhythmias, has been prepared by the American Heart Association's Committee on Medical Education.

Each of the panels illustrates a medical case, with x-rays and electrocardiograms correlated to the written case history. After studying these, and pertinent laboratory data illustrated on the panels, the physician answers multiple choice questions relative to each case.

The unit is intended for use at local or state medical meetings, as teaching exercises for medical students and house officers, and at hospital staff meetings. It may be obtained on a loan or purchase basis through local Heart Associations or the AHA National Office, 44 East 23rd Street, New York, New York 10010.

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1969

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Medical Journal

Official Organ of the West Virginia State Medical Association

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Member 1969

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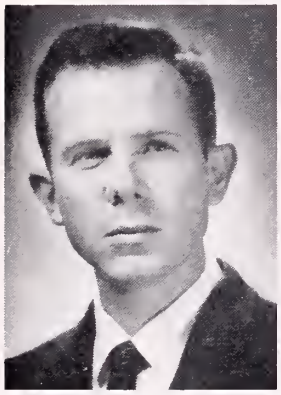
WVU Medical Center
—News—

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

The graduating class at the School of Medicine has dedicated its yearbook, *Pylon,* for 1969 to Dr. Wilford W. Spradlin, Professor and Chairman of the Department of Psychiatry.

At the annual awards convocation on May 2, Doctor Spradlin also was given an engraved silver plate in recognition of his being an "outstanding teacher and friend."



Wilford W. Spradlin, M. D.

The second-year class presented the MacLachlan Award to Dr. Donald Kimmel, Professor and Chairman of the Department of Anatomy. Doctor Kimmel was cited for "demonstrating unusual teaching ability and a sincere interest in the progress of the entire class."

Lange Book Awards were presented to two members of each class with high academic averages. Recipients were: Arthur Weinstein and Michael J. McGinnis, Seniors; Gary Marcus and Sandra Woolfitt, Juniors; Kenneth Derbenwick and Ted Lewis, Sophomores; and Robert Chalemian, Ronald Cyphers and Edgar Willard, III, Freshmen.

Sophomores receiving Mosby Book Awards for scholastic achievement were Nolan Parsons, Jr., George Zaldivar, Richard Gnegy, Michael Serene, Albert Young, and David Blass.

Merck Awards went to William L. Mossburg and James Castle, both Seniors. There was a tie between Mary Belle Taylor and Charles Cuono for the highest academic average in the sophomore class. Both were given Roche Awards.

The Lindsay Award, for outstanding performance by a Freshman in physiology, went to Edgar H. Willard, III. As the Senior woman with the highest scholastic average, Patricia S. Stewart won the Janet M. Glasgow Award, presented for the first time at WVU by the American Medical Women's Association.

The Edward G. Stuart Memorial Award went to James Mazzella. The award is given to the senior who "best exemplifies the qualities of empathy and understanding and strengthens his compentency with compassion."

Elliott Oaklander, a Senior, was the recipient of the Student American Medical Association-Eaton Award, and the E. J. Van Liere Award for student research went to Charles Loar, a Junior. Second place in the Van Liere competition went to Michael Atherton, a Sophomore; and Mary Frances Knapp, a Senior, and Terrence Steiner, a Junior, tied for third place.

New House Staff at WVU

Twenty-one young physicians are joining University Hospital this month for training as interns and residents. The states of West Virginia, Minnesota, Pennsylvania, Texas, Vermont, Wisconsin, New Jersey and Michigan are represented in the new contingent.

Rotating interns include Drs. Louis Balizet and Kenneth L. Wible of Philadelphia; Dennis D. Cook, Richard E. Goese, Eugene O. Hoxtell, Paul A. Huhn and Conrad H. Lunblad all of Minneapolis; Counce Hancock of Dallas, Texas; William R. Ricketts of Houston, Texas; Duane C. Record of Essex Junction, Vermont; and Harold E. Bondy, Steve N. Caritis, Roy G. Carter, Juan F. Gutierrez and Michael J. McGinnis, all of Morgantown.

New interns in medicine are Drs. Charles R. Buck of Brookfield, Wisconsin; Richard J. DuCharme and Irma H. Ullrich of St. Paul Minnesota; and John F. Franz II, of Maple Shade, New Jersey.

Surgery interns will be Drs. Ahmad Rahbar of Ann Arbor, Michigan, and Margaret S. Wells of Morgantown.

Pediatricians Are Elected

Two members of the faculty of the Department of Pediatrics have been elected to membership in medical specialty groups.

Dr. Barbara Jones, Professor of Pediatrics, was named to membership in the Society for Pediatric Research during the organization's meeting in Atlantic City. Dr. George H. Khoury, Assistant Professor of Pediatrics, became a Fellow of the American College of Cardiology during ceremonies in New York.

Medical Center Receives Grant

The West Virginia Fraternal Order of Eagles has voted a $10,000 grant for the Medical Center. The grant is to be used in advanced research in artificial heart valve development.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association has offered to cooperate in a Senate investigation of large Medicare and Medicaid payments to physicians and other health practitioners.

The offer followed a Senate speech by Sen. John J. Williams, (R., Del.), in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists and others had received $25,000 or more for their services under the two government programs in 1968.

In a second Senate speech, Senator Williams expressed appreciation for the AMA offer to cooperate.

"This is the type of cooperation we need, and I appreciate this support from the American Medical Association," Senator Williams told the Senate. "I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I can assure each of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming percentage of those who are in any way connected or working with this program are trying to do a good job; however, when instances of exploitation or excessive charges are discovered they must be exposed and properly dealt with."

Senator Williams, who has announced he will not seek reelection next year, is a member of the Senate Finance Committee which is making an extensive study of the operation of Medicaid and Medicare.

Senator Williams said that, although a staff report would not be ready until later this summer, the committee's investigation already had shown:—

"First, in 1968 the Medicare program paid $25,000 or more to each of at least 5,000 physicians.

"Second, thousands of health practitioners—doctors, dentists, optometrists, and others—were each paid $25,000 or more under the welfare health care programs in 1968. . . . A surprising note is the large number of dentists appearing on the lists from welfare agencies. . . .

"Data has also been gathered and detailed tables prepared comparing the average Medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same geographical area.

"The results are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country Medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by Medicare.

"The report to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds."

Following Senator Williams' first speech, the AMA issued a statement saying that it shared with the Senator a concern over the rising costs of Medicare and Medicaid. The Association offered to cooperate with the Senate Finance Committee or any other congressional committee studying the problem of rising health care costs. The AMA earlier had made the same offer to Health, Education and Welfare Secretary Robert H. Finch.

The AMA statement said:—

"For some time the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the Medicare and Medicaid programs. Close liaison also has been established between carriers and many medical societies in reviewing disbursements under the government programs.

"All investigations so far have indicated that an overwhelming majority of physicians participating in Medicare and Medicaid are charging reasonable fees. The charges of only about two per cent of the physicians receiving payments from the programs have been challenged. Of course, the AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. Last June, the AMA Board of Trustees urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' In 1967, the AMA said 'any reports of abuses by physicians or by any other health care program should be thoroughly and promptly investigated and action taken where indicated.' Several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program."

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Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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Obituaries

HARRY STANLEY KEISTER, M. D.

Dr. Harry S. Keister, 84, a retired Fairmont physician, died at his home in that city in June.

A native of Pendleton County, Doctor Keister had practiced for more than 50 years prior to his retirement. A graduate of the Valparaiso College of Pharmacy, Doctor Keister received his M. D. degree from the Chicago College of Medicine and Surgery in 1912.

He did postgraduate work at Johns Hopkins University Hospital and in Switzerland and Austria. He was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association, and he also was a member of the American College of Surgeons.

During World War I, Doctor Keister served as a Lieutenant in the Medical Corps of the United States Army.

Survivors include the widow, Mrs. Toyie Hupp Keister; a brother, Leslie A. Keister of Upper Tract; and a sister, Mrs. John Kee of Franklin.

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EARLE L. SHAMBLEN, M. D.

Dr. Earle L. Shamblen, 68, died at his home in Charleston on May 25.

A lifelong resident of the Charleston area, Doctor Shamblen received his M. D. degree in 1928 at the Medical College of Virginia in Richmond. During World War II, he served as a Lieutenant Commander in the Medical Corps of the U. S. Navy.

Doctor Shamblen practiced general surgery. He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. His other professional memberships included the American Society of Abdominal Surgeons and the American College of Surgeons.

Survivors include the widow, Mrs. Sally Shamblen; a son, Cooper E. Shamblen of Jacksonville, Florida; a stepson, Terry Redden of Satellite, Florida; daughters, Mrs. Robert York II and Mrs. Steve Kickhoff of Naples, Florida; and a stepdaughter, Mrs. Frederick Iuretig of Tarentum, Pennsylvania.

* * * *

EDWIN BRICE THOMPSON, M. D.

Dr. Edwin B. Thompson of Montgomery died in a Huntington hospital on May 21. He was 78.

A native of Lore City, Ohio, Doctor Thompson received his M. D. degree from the Medical College of Virginia in 1917. He retired in 1954 after practicing for 24 years in Montgomery.

He was a former member of the Fayette County Medical Society, the West Virginia State Medical Association and the American Medical Association.

A brother, Frank S. Thompson of Lore City, survives.

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County Societies

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Stevens Clinic Hospital in Welch on May 14.

Dr. Robert Hansen reported on a series of cases of Meckel's Diverticulum during the scientific program.

The Society adopted a motion calling upon McDowell County to establish a morgue.—J. C. Ray, M. D., Secretary.

* * * *

MERCER

Dr. Max P. Rogers and Miss Marjorie Rincic were guest speakers at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on May 19.

Doctor Rogers, Chief Surgeon of the Southern Railway, gave an interesting talk on industrial medicine. He emphasized the dangers of federal controls and discussed the Federal Employees Liability Act., which affects railroad workers.

Miss Rincic gave a presentation of her duties as dietician with the Southern Regional Appalachian Health Council.—John J. Mahood, M. D., Secretary.

MONONGALIA

Dr. Leonard M. Davis was guest speaker at the regular monthly meeting of the Monongalia County Medical Society, which was held on May 6.

Doctor Davis, Professor and Chairman of the Department of Speech at West Virginia University, gave an excellent talk on communication.—W. Gene Klingberg, M. D., Secretary.

* * * *

RALEIGH

The regular monthly meeting of the Raleigh County Medical Society was held at Henry's Restaurant in Beckley on May 15 with 42 members and guests in attendance.

Dr. Forest A. Cornwell, President, appointed Dr. Asa Barnes to attend meetings of the Council of the Raleigh County Community Health Project.—John M. Daniel, M. D., Secretary.

* * * *

TYGART'S VALLEY

Dr. Warren L. Moorman of Roanoke, Virginia, was guest speaker at the regular monthly meeting of the Tygart's Valley Medical Society, which was held on May 15 in Elkins.

Doctor Moorman, a plastic surgeon, gave an interesting talk on "Application of Plastic Surgery to Skin Lesions."—A. Kyle Bush, M. D., Secretary.

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J. N. Aceto, M. D.

Speech Pathologist and Audiologist:
James P. Frum, M. S.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Betty Maguire, R. N.
Electroencephalography:
Joann Green, R. N.
Juanita Stone, R. N.
Roentgenology:
Evelyn Forester, R. T.

Administration:
Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

Book Reviews

THE EVOLUTION OF PREVENTIVE MEDICINE IN THE UNITED STATES ARMY, 1607-1939—Stanhope Bayne-Jones, M. D., Brigadier General, USAR, Retired, Deputy Chief, Preventive Medicine Service. Office of The Surgeon General, in World War II. Office of the Surgeon General, Department of the Army, Washington, D. C. 1st Edition, 1968. Pp. 255. Illustrated. Price $2.50.

On the first look at this volume, one says to himself repeating the title, noting the dates and the size and weight of this small blue volume with its silver embossed title and meditates a moment or so. What is the idea of a pre-Revolutionary date anyhow?

It is all explained in the pages. The volume is an unofficial historical narrative and analysis and not a manual, and is really a highly informative monograph.

In the past, little attention was paid to preventive medicine, and it was seemingly squeezed in between medical administration and the care of the sick and wounded.

The association of our soldiers and officers with their opposites in the British Army taught us the principles and practice of military sanitation, hygiene and preventive medicine.

The illustrations are all clear and well documented. The narrative itself covers a period of 332 years, from Jamestown, May 1607, to the outbreak of World War II in Poland on 1 September 1939.

This volume is divided into parts composed of combined accounts, significant events in military preventive medicine and civil public health. It is well printed, excellently indexed, and easily read. It is also reasonably priced at $2.50. It also is a volume to relax by; taken on a trip, it is good company and as the chapters or divisions are short, it also makes a good bedside source of reading. It is an excellent gift. It is, in short, a fine book to own and can be read by physicians in all specialties.—C. Frederick Fisher, M. D.

National Watershed Congress Cites Brush Creek

The National Watershed Congress has cited Brush Creek in Mercer County as America's "Watershed of the Year" for 1969.

The award was presented to a West Virginia delegation headed by Dr. Daniel Hale of Princeton at the Congress's 16th Annual Meeting in Louisville, Kentucky, on June 8.

Doctor Hale, a member of the West Virginia State Medical Association, has been active in conservation circles for many years. He has been closely identified with the Brush Creek project.

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to the

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Vice President: Mrs. Arthur A. Abplanalp, Charleston
Eastern Regional Director: Mrs. Charles E. Andrews, Morgantown
Northern Regional Director: Mrs. Herbert Dickie, Wheeling
Western Regional Director: Mrs. Joseph E. Ricketts, Huntington
Southern Regional Director: Mrs. J. E. Blaydes, Jr., Bluefield
Treasurer: Mrs. William T. Lawson, Fairmont
Recording Secretary: Mrs. Richard G. Starr, Beckley
Corresponding Secretary: Mrs. James H. Walker, Charleston
Parliamentarian: Mrs. George A. Curry, Morgantown

Ohio County Auxiliary Wins Table Setting Contest

The Woman's Auxiliary to the Ohio County Medical Society won a "Best Dressed Tables" contest sponsored by a silver manufacturer recently.

The formal dinner party setting was entitled "First Centennial Celebration." The table was set as it might have been 100 years ago. Place cards bearing the names of prominent Wheeling citizens of a century ago added a touch of originality to the entry.

For the prize-winning entry, the Auxiliary received $100, which it is donating to AMA-ERF. The victory also gives the Ohio Auxiliary a chance to participate in a national contest in New York City, August 4-6.

Members of the Table Committee are Mrs. William F. Park, Mrs. Edgar Barrett, Mrs. D. E. Greeneltch and Mrs. Frank Hudson. Two of them will go to New York for the national contest.

* * * *

EASTERN PANHANDLE

Three officers of the Woman's Auxiliary to the West Virginia State Medical Association were guests at a meeting of the Auxiliary to the Eastern Panhandle Medical Society at the home of Mrs. George Pugh in Martinsburg in May.

The guests were Mrs. John A. B. Holt of Charleston, President of the State Auxiliary; Mrs. James H. Walker of Charleston, Corresponding Secretary; and Mrs. Charles E. Andrews of Morgantown, Eastern Regional Director.

* * * *

FAYETTE

A surprise luncheon honoring Mrs. Joe N. Jarrett was combined with the regular monthly meeting of the Woman's Auxiliary to the Fayette County Medical Society, which was held at the home of Mrs. C. H. Lee in Oak Hill on May 6.

Mrs. Jarrett will be installed as President of the Woman's Auxiliary to the West Virginia State Medical Association at The Greenbrier in August.

New officers of the Fayette County Auxiliary were installed, and they are as follows: Mrs. George Fordham, President; Mrs. A. R. Bautista, President Elect; and Mrs. J. B. Thompson, Secretary-Treasurer.

Guests at the meeting included Mrs. J. E. Blaydes, Jr., of Bluefield, Southern Regional Director of the Woman's Auxiliary to the West Virginia State Medical Association; and Mrs. John J. Mahood, also of Bluefield.

* * * *

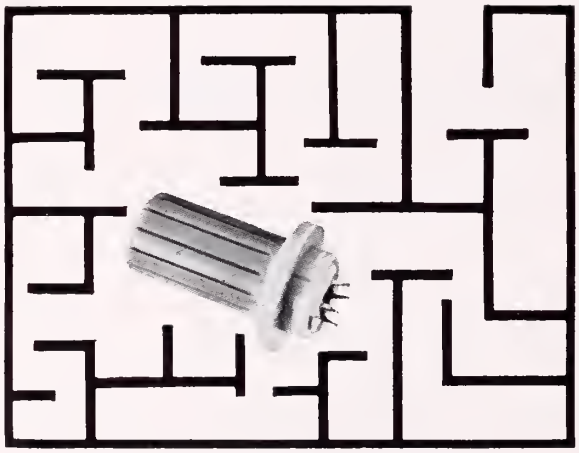
KANAWHA

New officers of the Woman's Auxiliary to the Kanawha Medical Society were installed during a tea held in May at the home of Dr. and Mrs. A. A. Abplanalp in Charleston.

Mrs. James H. Walker of Charleston, Past President of the Kanawha Auxiliary and now Corresponding Secretary of the Woman's Auxiliary to the West Virginia State Medical Association, presided at the installation.

Mrs. Willis Garrard took office as President of the Auxiliary. Other new officers for the coming year are as follows

Mrs. W. Alva Deardorff, President Elect; Mrs. Donald Hassig, First Vice President; Mrs. Julius Berkley, Second Vice President; Mrs. Alfred J. Magee, Third Vice President; Mrs. C. Carl Tully, Fourth Vice President; Mrs. L. Douglas Curnutte, Corresponding Secretary; Mrs. Marion Jarrett, Recording Secretary; and Mrs. C. E. Stennett, Treasurer.



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Correspondence

2255 Cherry Avenue
Huntington, W. Va.
June 7, 1969

Mr. William H. Lively, Managing Editor
The West Virginia Medical Journal
1526 Charleston National Plaza
Charleston, W. Va. 25301

Dear William:

At the present time it would be a physical impossibility for me to personally thank the many professional colleagues, who with their wives sent greetings on our 50th anniversary.

To think that 50 years ago this very minute I walked the bride to her wedding with $6.65 in my pocket, of which the preacher got five and I had $1.65 left to start married life with, and today I have about the same amount of cash, but we have gained a host of wonderful friends over the entire State.

Would you be good enough to place this note in the next *Journal* as a note of gratitude to these thoughtful people.

Sincerely,
/s/ James S. Klumpp, M. D.

AAMC Receives $121,600 Kellogg Grant

The W. K. Kellogg Foundation has announced a two-year grant of $121,600 to the Association of American Medical Colleges to develop an educational program for business officers in the nation's medical schools.

While the Foundation support will cover only the initial two years, the AAMC plans to make this educational program a permanent part of its services to medical schools.

102ND ANNUAL MEETING, THE GREENBRIER, AUGUST 21-23, 1969

PHYSICIAN WANTED

Young physician interested in industrial medicine—Must be licensed or eligible for license in West Virginia. Write or call collect James H. Thornbury, M. D., E. I. Du Pont de Nemours & Co., Inc., P. O. Box 635, Belle, West Virginia 25015. Telephone: 304 - 949-4313.

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WANTED—Physician to take over office and practice of recently deceased physician in Charleston. Financial help available. Contact Mr. Sam Michels, Trust Officer, Bank of West Virginia, Charleston, W. Va. Telephone 344-1621.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

INTERNIST—Needed in town located on the Ohio River. No investment needed. Office facilities near modern hospital. Write BAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—GP for Northern West Virginia town of 3,000. Good schools, recreational facilities and shopping. Fifteen-minute drive from hospital. Excellent practice opportunity. Contact Mr. Claud C. Kendall, 12 Jefferson Street, Mannington, W. Va. Telephone: 986-1242.

PHYSICIAN WANTED—An experienced general practitioner to add to and work with an established salaried group in metropolitan area. This provides regular hours and minimal night work. Contact Charles E. Staats, M.D., 123 West Washington Street, Charleston, W. Va. 25302.

WANTED—Excellent opportunity for general practitioner in Glenville, W. Va. Citizens of the community will provide medical facility, local financing and assistance in acquiring housing. Part-time services needed at Glenville State College with equipped infirmary and guaranteed salary. Hospital within 20 miles, new hospital to be constructed 28 miles away. Many recreational facilities available. Contact Mr. Donald L. Fogus, Glenville State College, Glenville, W. Va. Phone 462-8335.

AVAILABLE—Board eligible general surgeon upon completion of training on June 30, 1969. Filipino, married, with ECFMG Certificate. Presently Chief Resident, finishing the fourth and final year of training in a Type I residency program. Write: Rafael E. Saladar, M.D., Illinois Central Hospital, 5800 Stony Island Ave., Chicago, Illinois 60637.

AVAILABLE—General surgeon upon completion of training in July 1969. Filipino, married, with ECFMG Certificate. Presently doing preceptorship to complete board requirements. Write: Roberto B. De Ocampo, M. D., 40 Prospect Avenue, Norwalk, Connecticut 06850.

WANTED—Urgent need for a physician to work in a 50-bed hospital in a small and pleasant community near Charleston. Live in or near hospital. Must be licensed in West Virginia. Prefer middle age or older physician in good health. Write DAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

PEDIATRICIANS WANTED—Board or Board Eligible. OEO Rural Health Program. Practice limited to hospital and clinic. Salary $21,000 to $24,000. Fringe benefits. Write Medical Director, Mountaineer Family Health Plan, Inc., Box 1149, Beckley, W. Va. 25801.

AVAILABLE—Board eligible surgeon, 31, married, three children. Filipino, with ECFMG certificate. Will consider any location or hospital. Contact Dr. Ricardo R. Javier, John J. Kane Hosptial, Pittsburgh, Pa.

WANTED—General practitioner for Cameron, West Virginia. Population 1,700, urban and rural practice. Net income $5,000 per month. Quiet, picturesque town, 20 miles from both Wheeling and Moundsville. Possibility of clinic being built through Sears-Roebuck Foundation. R.N. and L.P.N. available. Excellent prospects. Contact Harry Harpold, Bank Building, Cameron, West Virginia.

AVAILABLE—Board certified pediatrician, 32, married, one child. Currently serving as staff pediatrician at a child health center at a major university. Will consider any pediatric position in West Virginia. Write JEB, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Board eligible surgeon, 31, married, one child. Will complete training June 30, 1969, and will consider any general surgery position in West Virginia. Currently serving as chief resident at a university hospital. Write GDD, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED IMMEDIATELY—A general surgeon for a modern 40-bed well-equipped hospital. We have five general practitioners on the medical staff who do not practice surgery and will refer to a qualified surgeon. Income limited only by desire and ability. Write or call Administrator, Hampshire Memorial Hospital, Romney, W. Va. 26757. Phone 304-822-3514.

OB-GYN RESIDENCY—Approved three-year program. Position available for first year. A program designed to prepare for complicated obstetrics and general gynecologic surgery. Abundant indigent experience. Active education programs in the other departments. Contact Director of Medical Education, Memorial Hospital, 3200 Noyes Avenue, Charleston, W. Va. 25304.

RESIDENCIES AVAILABLE—Resident positions available in the following: First and second year positions of a fully accredited four-year general surgery residency. One position available in the first year and one available in the second. Phone or write to the Director of Medical Education, Memorial Hospital, Charleston, W. Va. 25304.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal. P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

AUGUST
1969

Vol. 65 No. 8

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1969

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DOW

WVU Medical Center
—News—

SEVENTY-FIVE young men and women will begin studies as first-year medical students at the West Virginia University School of Medicine next month. All but two members of the class—expanded from 68 places—are West Virginians.

Almost 2,000 letters of inquiry were received by the registrar's office from prospective students and 369 applications were filed. The new class will include nine women.

Both of the out-of-staters are from Pennsylvania. They are Thomas S. Kickler of Belle Vernon and Emerson L. Knight, Jr., of Penryn. Following is a list of first-year students from West Virginia, by counties:

BERKELEY—Phyllis I. Riley of Falling Waters, and William J. Sembello of Martinsburg; BRAXTON—Vera L. Hoylman of Gassaway; CABELL—Larry A. Caserta of Barboursville, and Rodney D. Dean, Barbara J. Farrell, Homer P. Hatten, Jr., Jerome M. Schnitt, Joseph W. Werthammer, Gordon D. Willey and Stephen I. Lester, all of Huntington.

GRANT—Malcolm M. Alt of Petersburg; GREENBRIER—Joseph E. Shaver of Lewisburg, and Kathleen A. O'Farrell of White Sulphur Springs; HANCOCK—Michael R. Cashdollar of Chester, Thomas L. Stover of New Manchester, and Robert E. Bushman and William Darrell Martin, III, both of Weirton.

HARRISON—John L. Benedum of Bridgeport, Peter K. Thrush of Clarksburg, Deborah J. McCloud of Mount Clare, and Jackson J. Woods of Shinnston; JACKSON—James A. Stewart of Ripley; LOGAN—Danny M. Linkous and Alexander J. Chillag, both of Holden, and Robert K. Scott of Logan.

KANAWHA—Ann K. Burton, Stephanie A. Deverick, Brittain McJunkin, John A. Wade, Jr., Rodney R. Williams, and Joseph D. Wright, all of Charleston, Robert L. Hively of Dunbar, Richard D. Glock, James Emory Loyd and John G. Stansbury, all of South Charleston, and John H. Brooks, William T. Harless and Donald A. Withrow, all of St. Albans.

MARION—Kenneth W. Brock, Thomas C. Jones and Stanard L. Swihart, all of Fairmont; MINERAL—Sally H. Swisher of New Creek; MINGO—Russell A. Salton, III, of Williamson; MONONGALIA—Patrick J. Condry, David J. Fogarty, Archie T. Hupp, IV, David C. McClure, and Thomas A. Reeder, all of Morgantown.

NICHOLAS—Benjamin T. Brown of Summersville, and John R. Hitt and Stephen K. Milroy, both of Richwood; OHIO—Charles W. Buffington, Evan S. Pokorney and Bruce David Wapen, all of Wheeling; PRESTON—Ivan R. Schwab of Kingwood, and Edward F. Arnett of Rowlesburg.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

RALEIGH—Lewis A. Cook, Richard N. Halstead and Bill B. Richmond, Jr., all of Beckley; ROANE—David T. Murray of Spencer; TYLER—Gregory B. Knowlton of Sistersville; WAYNE—John C. Lambert of Wayne; WETZEL—Wilbur Z. Sine of Hundred, and Jan H. Cunningham, Leon J. Davis and David M. Nally, all of New Martinsville.

WOOD—David R. Finch and Christine Marie Grant, both of Parkersburg, John W. Gilmore, II, of Vienna, and Edward A. Waybright of Williamstown; WYOMING—William A. Davis, II, and Joel R. Thompson, both of Mullens.

Pediatric Programs Affiliate

Ties linking northern and southern West Virginia more closely in medical education and patient care were strengthened recently when a contract involving two pediatric residency programs was approved. The contract is between Department of Pediatrics at the Medical Center and its counterpart at Appalachian Regional Hospital in Beckley.

Signatories said the agreement will help foster more interest in pediatrics, correlate aspects of the teaching program and promote the welfare of children whose care comes within the scope of the participating sections of either institution. Members of the faculty of the WVU Department of Pediatrics will visit the Beckley facility for teaching purposes regularly, and the affiliation will be listed officially by the Council on Medical Education of the American Medical Association.

The contract resulted from discussions between Dr. W. Gene Klingberg, Professor and Chairman of the Department of Pediatrics at WVU, and Dr. Forest A. Cornwell, Chief of Pediatrics at the Appalachian Regional Hospital. They expressed the belief that both medical centers will benefit from the affiliation.

SAMA Appalachian Program

Some 100 medical and 20 nursing students from throughout the nation are participating in health care of residents in rural areas of West Virginia, Pennsylvania, Kentucky, Ohio, and North and South Carolina.

Participants in the Student American Medical Association's Summer Appalachian Program gathered for an orientation session at WVU, June 21-23. After two

(Continued on Page xxviii)

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David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than $25,000 a year in Medicare and Medicaid payments.

Plans for the special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' Social Security numbers on reports of payments under the program in the future.

Finance Committee Chairman Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of $25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than $50,000.

Long said that the investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

Robert M. Ball, Social Security Administrator, reported his investigators had looked into more than 700 possible fraud cases under Medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"But these should not be taken as a reflection on the 200,000 doctors participating in Medicare," Ball said. He added a bigger problem than outright fraud were "cases that don't quite become fraud."

HEW Undersecretary John G. Veneman told the Committee that the Nixon Administration wants congressional authority to stop Medicare payments to doctors who overcharge, use inferior supplies or engage in fraud.

"Under present Medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful," Veneman said.

"We are recommending authority . . . to discontinue future reimbursement and to put all parties on notice to this effect where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

Commenting on the hearings, Dr. Dwight L. Wilbur, President of the American Medical Association, said that the vast majority of physicians serving Medicaid patients are not overcharging for their services.

"Most physicians," Doctor Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few M. D.'s participating in Medicaid are guilty of overcharging and otherwise exploiting the program. Such exploitation by a minuscule minority was unavoidable. . . .

". . . The medical profession is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose them, for the good of the entire profession."

Medicaid Fees Limited

Meantime, HEW issued a regulation limiting the fees paid by states to physicians, dentists and other health practitioners under Medicaid.

Under the regulation, a state's Medicaid payment to a physician for a service will be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

If a state has been paying more than the 75th percentile of the customary charge, it must not exceed the Medicare level, about the 83rd percentile. A Medicaid official said that only two states may have to roll back their fees, but declined to name them.

After July 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

The average percentage increasc requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.

Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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Obituaries

WILLIAM MADISON RILEY, M. D.

Dr. William M. Riley of Mabscott died in a Beckley hospital on June 13 following an illness of nine months. He was 91.

A native of Colquitt, Georgia, Doctor Riley had retired several years ago. He received his M. D. degree in 1901 from the University of Maryland College of Medicine.

During World War I, Doctor Riley served as a First Lieutenant in the Medical Corps of the U. S. Army. He was an honorary member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association. He practiced medicine in Arlington, Georgia, and Martin, Kentucky, before moving to Whitby, Raleigh County, in 1931.

Survivors include a son, George G. Riley of Atlanta, Georgia; a daughter, Mrs. Charles Simmons of Americus, Georgia, and a sister, Mrs. Heyes McMath of Americus.

* * * *

WILLIAM JEFFERSON SMITH, M. D.

Dr. William J. Smith, 86, of Belfry, Kentucky, died on June 29 at his home after an eight-month illness.

A native of the Kentucky community of Canada, Doctor Smith received his M. D. degree from the University of Louisville School of Medicine in 1909. He was engaged in general practice until his retirement last fall.

He maintained a medical practice in Williamson, West Virginia, and Stone, Kentucky, before moving to Belfry.

Doctor Smith was an honorary member of the Mingo County Medical Society, the West Virginia State Medical Association and the American Medical Association. He served two terms as a Democratic member of the Kentucky Legislature beginning in 1932 and 1958.

Survivors include the widow, the former Miss Vida Good; one son, Navy Capt. Robert G. Smith of Louisville, Kentucky; one daughter, Mrs. Mary Jane Gorman of Evansville, Indiana; seven grandchildren; six great grandchildren; one brother, Lafe B. Smith of Sidney, Kentucky; and six sisters, Mrs. Ida Repast of Pikeville, Kentucky, Mrs. Emile Reed of Canada, Kentucky, Mrs. Lennie Reed of Meta, Kentucky, Miss Mary Smith of Oak Ridge, Tennessee, Miss Bess Smith of Fort Pierce, Florida, and Mrs. Elizabeth Runyon of Canada, Kentucky.

* * * *

KARL H. TRIPPETT, M. D.

Dr. Karl H. Trippett, an 83-year-old resident of Grafton, died on June 23 in a hospital in Philippi.

A native of Calhoun County, Doctor Trippett received his M. D. degree in 1911 from the College of Physicians and Surgeons in Baltimore, Maryland. In 1963-64, he was President of the old Taylor County Medical Society.

Doctor Trippett was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association, the Southern Medcial Association, the American Medical Association, the American Association of Railway Surgeons and the Association of American Physicians and Surgeons.

He leaves a son, Karl H. Trippett of Marysville, Ohio, and two nieces.

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WVU MEDICAL CENTER NEWS—(Continued)

months of working under the supervision of physicians in the six states, the future physicians and nurses will return to WVU for an evaluation program, August 21-23.

The project is funded through a contract with the Appalachian Regional Commission. The preceptorships provide $700 plus room and board for each student.

Participants are assisting physicians in an office setting, conducting community health surveys, assisting at immunization and migrant clinics, observing home health aids, and assisting in the operation of infant and child health clinics.

Dr. Richard V. Lynch, Jr., Assistant Professor of Medicine and Director of the Outpatient Department at WVU Hospital, is a member of the Appalachian Regional Commission's Medical Review Panel. He is one of six advisers for the summer program.

SAMA area coordinators will keep abreast of the project and will make a progress report. These include Gordon Minns, Jr., of Spencer, a second-year medical student at WVU.

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A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $5.00 postpaid.

County Societies

RALEIGH

Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Raleigh County Medical Society, which was held at Henry's Restaurant in Beckley on June 19.

Doctor Corbitt gave an interesting talk on "The Problems Pertaining to the Medical Profession in the State of West Virginia." The President answered questions afterward.

Guests at the dinner meeting included members of the Woman's Auxiliary to the Medical Society, resident physicians, new physicians in the area and medical students.—John M. Daniel, M. D., Secretary.

Occupational Health Congress In St. Louis Next Month

The 20th Annual Congress on Occupational Health will be held at Stouffer's Riverfront Inn in St. Louis, Missouri, September 15-16, under the sponsorship of the American Medical Association's Council on Occupational Health.

Additional information may be obtained by writing to Department of Occupational Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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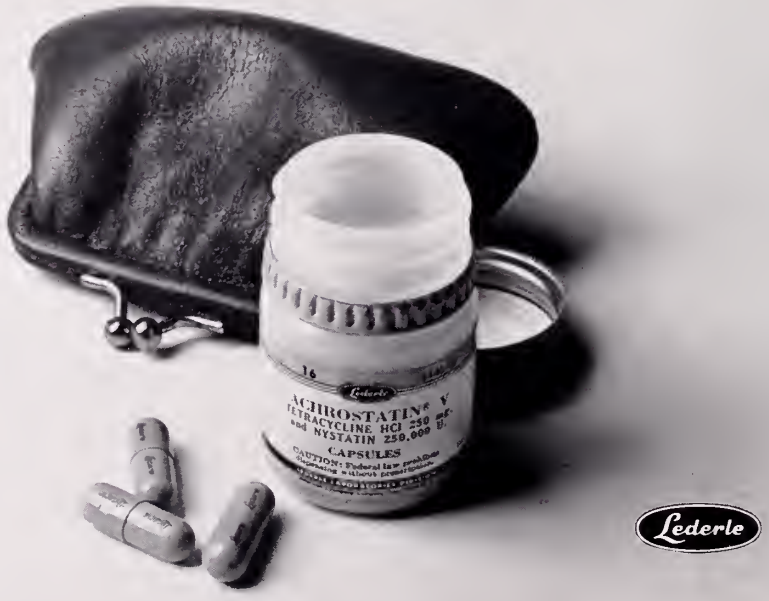

Book Reviews

MEDICAL SUPPLY IN WORLD WAR II—Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor in Chief, Colonel Robert S. Anderson, MC, USA. Washington, D. C. 1968. Pp. 662. Illustrated. Price: $8.25.

This volume is a true story of the War, for where the War was also could be found the magnificent and overworked and often unnecessarily blamed medical supply.

At no time or place in this world could such an enormous "business" be created so rapidly and so efficiently managed.

This is not a "dream book," but one of cold, hard reality, for the treatment of such and/or wounded officers and soldiers requires all materials related to their needs. New techniques of packing medicines, plasma and blood, even for dropping by parachute are noteworthy and many others.

Twenty-five medical sections, general depots and medical depots and two depots for international aid, existed between 1939 and 1946. All are recorded.

If you were a commanding officer of an evacuation, station or general hospital, or a chief of a service, the sample equipment lists in Appendix C of this volume would give you a serious reflection on what at one time was an enormous responsibility.

The war effort of the Medical Department was the care of any and all types of conditions of about eight million people.

"The process began with forecasting requirements for global war and planning procurement. In the magnitude of this task more than a billion pounds of medical supplies were purchased between July 1, 1941, and June 30, 1945, at a total cost of over one billion dollars." Packed in freight cars, the items purchased over this five year span would fill a train 400 miles long.

This volume has 59 contributors and 72 reviewers and from the enormity of these groups its value can be further appreciated.

This volume is totally readable and beautifully arranged in three parts:

I. Procurement and distribution of medical supplies in the zone of interior.

II. Medical supply in the war against the European Axis.

III. Medical supply in the war against Japan. There exists 149 illustrations, all clear with appropriate legends, 54 maps, and 8 tables, all described in the text.

For the full appreciation of this volume it should be owned and read, and also placed in libraries (medical) for it is really a record of a great achievement and a long list of unsung heroes.—C. Frederick Fisher, M. D.

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WHAT'S SO WEAK ABOUT THE WEAKER SEX?

DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES—Bernard E. Finneson, M. D., F.A.C.S., Chief of Neurological Surgery, Crozer-Chester Medical Center and Sacred Heart Hospital, Chester; and Taylor Hosp., Ridley Park, Pennsylvania. W. B. Saunders Company: Philadelphia & London. 2nd Edition, 1969. Pp. 337. Illustrated. Price 12.50.

There are 14 chapters in this book dealing with nearly all types of pain. There also are 207 useful illustrations. The format of the book is pleasing, and it is very readable. The text is clear, and it is written in easily understood language. The line drawings and illustrations show clearly how to locate sources of pain, how to inject drugs, and how to perform surgical procedures. Anatomical illustrations are clean cut and easily understood.

The contents by chapter are listed as follows: Chapter 1—Pain and Its Effects; Chapter 2—Psychology of Pain; Chapter 3—The Use of Drugs in Relief of Pain, and this chapter written by Arthur Grollman, M. D. Chapter 4—Analgesic Block; Chapter 5—The Management of Musculoskeletal Pain by Martin Meltzer, M. D.; Chapter 6—Headache; Chapter 7—Facial Pain; Chapter 8—Neck Pain and Cervicobrachial Neuralgia; Chapter 9—Low Back Pain and Sciatica; Chapter 10—Visceral Pain of the Chest and Abdomen; Chapter 11—Pain of Peripheral Vascular Disease; Chapter 12—Autonomic Reflex Pain; Chapter 13—Nerve Compression Syndrome, Painful Scars, Postherpetic Neuralgia; Chapter 14—Intractable Pain and Cancer.

Pages 329 to 337 are taken up with the Index, which is very satisfactory and complete, but which has the same fault of many Indices, namely that a number of headings are followed by the statement See—and other headings, and not giving the page where that original heading can be found. The descriptions of pathological entities, the anatomical basis for these, and the indicated treatment are explained in simple, easily understood detail. The print is rather small but easily read, and the headings are much larger and stand out in bold, black letters. The names of painful entities are often followed by signs and symptoms, directions about examination, and then the recommended treatment.

The book is compact enough to be comfortable and fit well on a shelf, yet is complete enough so that it is bound to be a most useful volume for students and for any doctor who treats patients with conditions causing pain. No errors were encountered in the review.

The reviewer is indebted to the author of Chapter 5 on the management of musculoskeletal pain, and the careful, meticulous treatment afforded me by this doctor would tend to recommend a volume with which he is associated. The book itself is commendable. I recommend Doctor Finneson's book to readers of this Journal.—E. Lyle Gage, M. D.

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CONGRESS OF THE UNITED STATES
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Washington, D. C.

Mr. William H. Lively
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Bill:

I was very much interested in the editorial which you sent me with your letter of June 30 because it recalled to my mind the days of my young manhood when the family physician was the source of much important counsel and advice for young people. I am disturbed by the manner in which this relationship between the family physician and the family unit seems to have eroded or has perhaps been superseded by other influences. I thoroughly agree with Dr. Eckmann that five minutes spent by each doctor at the end of his examination of new college students would constitute an influence which could not come from any other source. I hope there are thousands like him in the medical profession.

Yours sincerely,

/s/ John M. Slack, M. C.

(Note: The editorial was entitled "Planting the Seed" and it was published in the July issue of *The Journal*. It was written by Dr. Leonard M. Eckmann of South Charleston.

* * * *

THE WEBSTER ECHO
Webster Springs, West Virginia

The West Virginia Medical Journal
George F. Evans, M. D., Editor
Charleston, West Virginia

Dear Dr. Evans,

It was with encouragement and anticipation that I read the article in the Charleston Gazette entitled, "State Doctors Call For Help." Your publication, *The West Virginia Medical Journal*, can and no doubt will be of significant help to rural and urban areas alike in helping them to locate physicians. I commend you and your staff for accepting this extremely worthwhile challenge.

Webster County, as you no doubt know, is one of the most rural of West Virginia counties. Located in a mountainess area, this county is somewhat removed from the "main stream" of West Virginia activity. We are, however, proceeding with renewed determination in an effort to bring our county to the front.

Many problems and needs confront us in our endeavor. One is the lack of doctors. With an excellent medical facility in the Webster County Memorial, a modern county institution with a seventy-plus bed capacity and plans for a needed additional forty-plus beds, we are in dire need of at least one, and two if

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possible, physicians to join with the two fine doctors we have on the hospital staff.

We know well that obtaining the services of two more doctors will be extremely difficult, however, we feel that if assistance can be given us by persons such as yourself, we may realize our goal. If you could relate to us names and addresses of doctors, in state or out, who might be interested in locating in a rural area—a rural area with excellent facilities, opportunities for doing an almost limitless practice, and a sincere willingness upon the part of the citizenry to cooperate to the fullest in helping them to get settled —we would be most appreciative.

Hoping to hear from you in the near future and soliciting your help, I remain,

Sincerely,

/s/ D. Boyd Dotson, Jr., Member
Webster County Court

* * * *

— Reply —

Dear Mr. Dotson:

We will do anything possible to assist you in resolving your Doctor problem. We are deeply concerned about the physician shortage. We need general practitioners and specialists in all our rural areas and also in the cities.

Mr. Lively will mail to you all the inquiries we receive from out of state doctors. Please look over the enclosed page, form your ad and send to *The Journal* for free publication as long as you wish.

If any further information comes to my notice, I will forward same.

Sincerely,

/s/ George F. Evans, M. D.

Heart Association Plans Annual Meeting

The Annual Meeting and Scientific Sessions of the West Virginia Heart Association will be held September 12 and 13 at the Chancellor Hotel in Parkersburg.

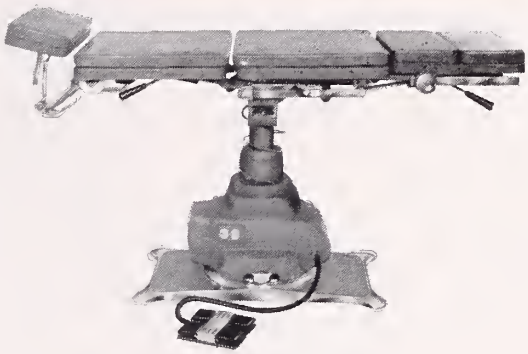
Dr. Robert J. Marshall of Morgantown, President of the Association, will preside at the opening session on Friday, September 12, beginning at 9 A.M. The morning scientific program will be presented by Dr. Roland Schmidt and Dr. Carolyn McCue.

Presiding Friday afternoon will be Dr. Richard V. Lynch, Jr., of Morgantown, President Elect of the Association. Afternoon speakers will include Drs. Michael Hunsaker, Everett C. Carter, Frederick J. Wegmann and Morris H. O'Dell.

The non-medical program for laymen will be presented by Drs. Schmidt and L. M. Eckmann and Dr. Paul Selby, Dean of The West Virginia University College of Law.

Several panel discussions will also be conducted on Saturday. They will concern Heart Association regionalization, policy and problems.

Additional information about the meeting may be obtained by writing to: West Virginia Heart Association, 211 35th Street, Charleston, West Virginia.



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SEPTEMBER
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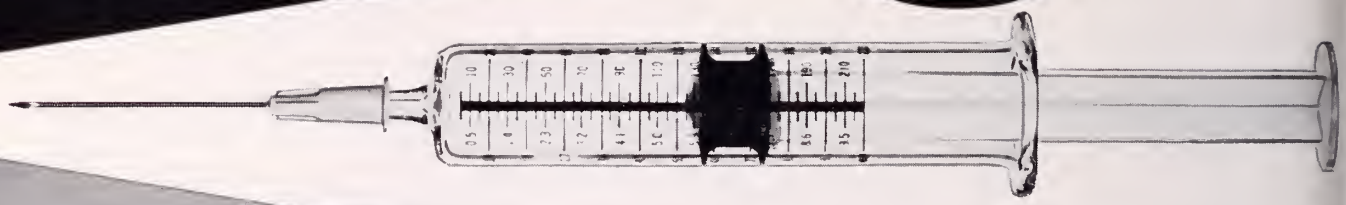

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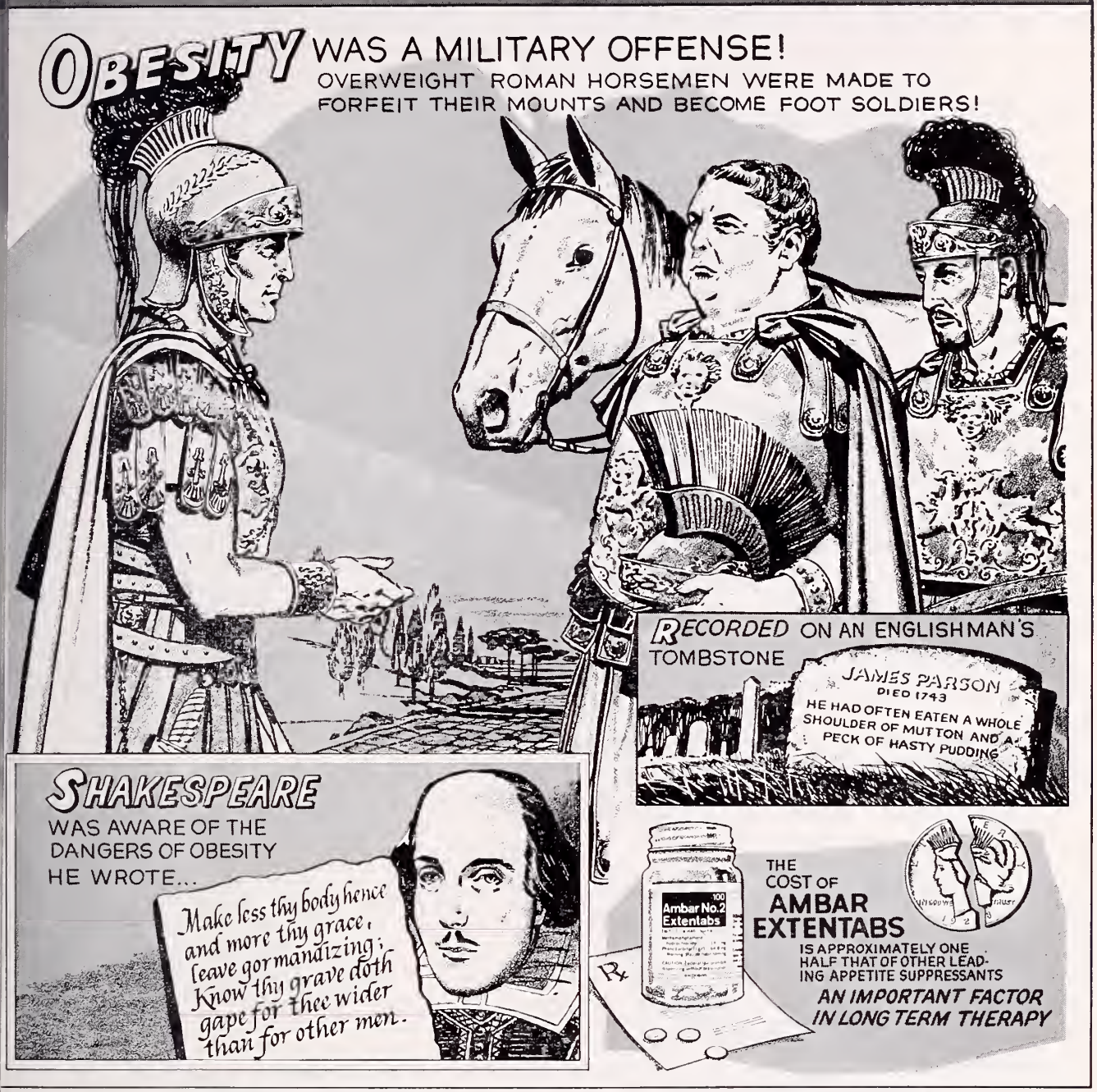

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WVU Medical Center
—News—

DR. Herbert E. Warden, Professor of Surgery, has been elected to his second full term as Chief of Staff of University Hospital.

Elected Assistant Chief of Staff, also for a second term, was Dr. John E. Jones, Associate Professor of Medicine. Dr. James D. Martin, Assistant Professor of Neurology, was named Secretary.

Elected as members at large of the Executive and Credentials Committee were: Dr. Barbara Jones, Professor of Pediatrics; Dr. W. Keith C. Morgan, Associate Professor of Medicine; Dr. N. W. B. Craythorne, Professor and Chairman of Anesthesiology; Dr. Stanley Shane, Assistant Professor of Medicine; and Dr. Richard A. Currie, Associate Professor of Surgery.

Doctor Thompson Resigns

Dr. Hartwell G. Thompson, Jr., Professor and Chairman of the Department of Neurology since 1964, has resigned.

Doctor Thompson accepted appointment as Professor of Neurology and Associate Dean for Student Affairs at the University of Pennsylvania School of Medicine.

A native of Hartford, Connecticut, Doctor Thompson received his M. D. degree from Cornell University Medical College in 1950. He was a member of the faculty of the University of Wisconsin School of Medicine prior to joining WVU. He is a diplomate of the American Board of Psychiatry and Neurology.

Dr. Ludwig Gutmann, Associate Professor of Neurology, has been named Acting Chairman of the Department at WVU.

ENT Residents Graduate

The four-year residency program at the Medical Center in otolaryngology has produced its first two graduates.

They are Drs. G. William Jaquiss and Fred D. Owens. Doctor Jaquiss will continue his graduate studies in head and neck surgery in Pittsburgh, and Doctor Owens will return to his native Kentucky, where he will practice otolaryngology in Lexington.

Other residents in the ENT program are Drs. A. Parke Avery and Trevelyn F. Hall, fourth year; Drs. Phillip B. Mathias and Phillip Andrews, third year; Drs. Anthony Oliverio and James Chicklo, second year; and Dr. Larry Dodds, first year.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

New Residents Are Announced

Several physicians have joined the Medical Center for graduate training in various medical and surgical specialties. They are as follows:

Anesthesiology—Drs. Roger G. Bucs, Francis C. Chuang and Dionisio R. Maracut, Jr.

Medicine—Drs. James A. Flueck (Fellow), Rudolf H. Fueter, Larry O. Harper (Fellow in Metabolism and Endocrinology), Lowell K. Johnson, Victor A. Kelmenson, Milo J. Meland, Jr., Joseph Renn, Michael Rietbrock, Jeung Rim, Suzanne B. Saliga (Fellow in Hematology) and Raymond B. Weiss.

Neurology—Drs. Patsy B. Cipolloni, Jr., and Walter Schenkel.

Obstetrics and Gynecology—Dr. Carl Nichols.

Ophthalmology—Drs. Jim R. Browning, Charles T. Kunesh and Larry T. Schwab.

Orthopedic Surgery—Drs. Richard L. Gaertner and Robert K. Hobbs.

Otolaryngology—Dr. Larry A. Dodd.

Pathology—Drs. Alexander J. Sabo, Wilson O. Uy, Yung P. Wu and Frederick T. Zugibe.

Pediatrics—Drs. Mary E. Hobbs, Suradech Kongkasuwan (Fellow) and Farid A. K. Waly.

Radiology—Drs. Terrence Demos (Fellow) Tristan M. Gale (Fellow), Won-Young Kim and Chang Lee.

General Surgery—Drs. Roberto J. Cabrera, William N. Capello, Donald D. Glass, Walid A. Khuri, Frank H. Moore, Carlos A. Naranjo, Jose A. Raquel, Jr., Sung Shin II, Elliott L. Thrasher II, and Ronald L. Wilkinson.

Doctor Sprinkle Lectures Abroad

Dr. Philip M. Sprinkle, Professor and Chairman of the Division of Otolaryngology, participated in scientific meetings in the British Isles last month.

He spoke during a postgraduate course for British otolaryngologists at the University of Dundee in Scotland, August 25-29. Among subjects he discussed were treatment of tumors of the ear, combined radiotherapy and surgery for cancer of the larynx, and laryngeal fractures.

Doctor Sprinkle, a member of the Royal Society of Medicine, also spoke at a hospital in London.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association questioned whether the Department of Health, Education and Welfare has the authority to issue its recent regulation limiting physicians' fees under Medicaid.

"We question whether the authority granted by the Congress embraces the promulgation of this regulation," Dr. Ernest B. Howard, Executive Vice President of the AMA, said in a letter to HEW.

"This regulation appears to reverse the roles of state and federal government established in the law itself."

The regulation limits most physicians' fees to the 75th percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

After offering HEW the cooperation of the AMA in its efforts to contain rising Medicaid costs, Doctor Howard pointed out that the "comprehensive" care goal of the program could not be achieved "without substantial funding, both state and federal."

"Moreover, it has always been recognized that the intent of Title XIX (Medicaid), when adopted, was to dissolve any barriers which existed between medical care available to the medically indigent and other citizens," the AMA statement said.

"It also recognized that payment to physicians participating in the government program should be on the basis of reasonable charges, i.e., usual charges of the physician within the customary range of charges for similar services in the community, so as to assure a broad range of participation by physicians in the program and eliminate one of the obstacles to the care of patients on the same level as that provided other persons in the community. This was essentially the approach taken in the January 25, 1969, regulations concerning "Reasonable Charges," in which "Customary charges which are reasonable" was established as the upper limit for payment for non-institutional services. We believe that the January 25th pronouncement more accurately comports with the Congressional intent expassed in Section 1903(a)(30) of the Medicaid law, than does the new regulation. . . .

"In departing from this earlier standard, by establishing arbitrary limits on payments to individual practitioners, it should be recognized that the July 1 regulations may again raise a barrier to providing private care to the medically indigent.

"There can be no question that any fee abuses in the program, whether by individual practitioners or other providers, must be ferreted out and eliminated. On the other hand, the true effect of the proposed regulations must be kept in proper perspective, since physicians' fees represent only approximately 11 per cent of the costs of the Medicaid program. Consequently, if the basic concern is with the total costs of the program, the remedy in our opinion is not through regulations which restrict physicians' charges."

Medicaid Law Amended

On the Congressional front, the Medicaid law was amended to give the states some relief in fiscal difficulties arising from the program.

States now have until July 1, 1977, to submit comprehensive plans of medical care for all needy persons under Medicaid. Under the original Medicaid law, participating states had to come up with such a plan by July 1, 1975. But rising health care costs resulted in Medicaid fiscal difficulties for so many states that Congress delayed the deadline for two years and relaxed other requirements to ease the financial bind.

One of the new amendments permits states to reduce their services under Medicaid. In the past, they could not do so. But a state still cannot reduce overall Medicaid spending.

Statement by President Nixon

President Nixon said the nation will be confronted with a "massive" crisis in health care unless government and the private sector cooperate to hold down costs and to improve the system of delivery of medical services.

He made the statement in commenting on Health, Education and Welfare Department's "Report on the Health of the Nation's Health Care System." It carried the names of both HEW Secretary Robert H. Finch and HEW Assistant Secretary for Health and Scientific Affairs Roger O. Egeberg, M. D.

"This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector," the report said. "Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond. The result is a crippling inflation in medical costs causing vast increases in government health expenditures for little return, raising private health insurance premiums and reducing the purchasing power of the health dollar of our citizens."

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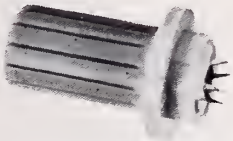

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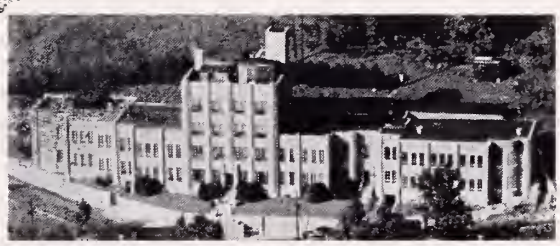

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Obituaries

SAMUEL CHARLES DOTSON, JR., M. D.

Dr. Samuel C. Dotson, Jr., 53, a physician for the West Virginia University Health Service, died on July 23 in a Morgantown hospital. Death was due to an apparent heart attack.

A native of Richwood, Doctor Dotson attended West Virginia University, where he received a B. S. degree in 1937. He received his M. D. degree at the Northwestern University School of Medicine, and served his internship at Ohio Valley General Hospital in Wheeling.

Doctor Dotson was engaged in the private practice of medicine in Cameron from 1940 until 1960, when he joined the WVU Health Service.

His professional memberships included the Monongalia County Medical Society, the West Virginia State Medical Association, the American Medical Association and the American Academy of General Practice.

Survivors include the widow, Mrs. Campsa Snedeker Dotson; two sons, Samuel Charles III, and Robert William, both at home; one daughter, Mary Ann Dotson of Durham, North Carolina; the mother, Mrs. Mary Elizabeth Dotson of Morgantown; and four sisters, Mrs. W. W. Price of Mt. Lake Park, Maryland, Mrs. O. J. Gustafson of Dearborn Heights, Michigan, Mrs. James A. Roberts of Glenshaw, Pennsylvania, and Mrs. Paul W. Koenemund of Glen Dale.

* * * *

LOUIS B. FARRI, M. D.

Dr. Louis B. Farri, 74, of Wheeling, died in a hospital in that city on July 31.

Born in Walston, Pennsylvania, Doctor Farri attended the Liceum in Salerno, Italy, and the University of Naples. He received his M. D. degree from the University of Padua in Bologna, Italy.

He was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association. He

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was also a member of the Southern Medical Association.

Doctor Farri leaves his widow, Mrs. Angela Ippoliti Farri, a son, Dr. Joseph L. Farr of Wheeling; a daughter, Mrs. Virginia Giustini of Wheeling; a brother, Matthew and a sister, Mrs. Caterina Palazzo, both of Italy; and six grandchildren.

Academy of Pediatrics Urges Reflectors for Children

The American Academy of Pediatrics has strongly recommended that retro-reflective materials such as reflectorized tags attached to a child's coat zipper be worn by children at night. This, the Academy emphasizes, will help to significantly reduce the more than 1,000 childhood deaths attributed each year to poor visibility during evening hours.

In a statement appearing in the AAP *Newsletter*, the Academy Committee on Accident Prevention encourages the development of various commercial reflectorized material to make pedestrians readily visible to drivers at night.

Retro-reflectorized materials, the Academy statement emphasizes, can either be affixed to clothing, or incorporated in the design of a garment.

The Academy further recommends that more information concerning traffic safety be given to pediatric patients.

The American Academy of Pediatrics has more than 10,800 members in the United States, Canada, and Latin America.

AHA Scientific Sessions In Dallas, Nov. 13-16

Registration forms for the 1969 Scientific Sessions of the American Heart Association may now be obtained from the Association's National Office or through local Heart groups.

The meeting covers a four-day period from Thursday, November 13 through Sunday, November 16 in Dallas' Memorial Auditorium. It features eight sessions on clinical cardiology of special interest to the practicing physician, simultaneous sessions on various aspects of cardiovascular research and medicine, lectures, panels, symposia and an all-day showing of recently-produced cardiovascular films.

Highlights of the meeting include presentation of the Research Achievement Award; the International Lecture by Dr. J. Fraser Mustard; the Conner Memorial Lecture and the Brown Memorial Lecture.

Saturday evening's program features a number of conferences for small group discussion of cardiovascular problems.

Scientific and industrial exhibits will be displayed throughout the four-day meeting. Space for industrial exhibits may be obtained through Steven K. Herlitz, Inc., 850 Third Avenue, New York, New York 10022.

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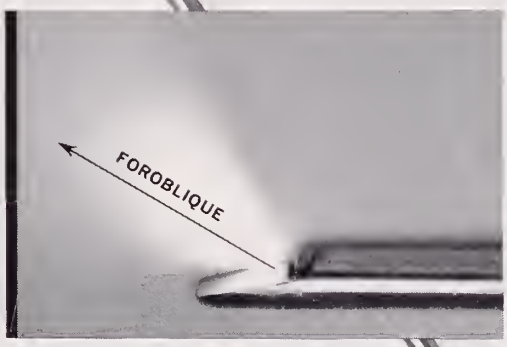

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County Societies

MONONGALIA

Three resident physicians at University Hospital in Morgantown presented the scientific program for the regular monthly meeting of the Monongalia County Medical Society, which was held on June 3.

The following papers were presented: "Studies in Idiopathic Hirsuitism and Amenorrhea" by Dr. Charles Jacobson; "Artificial Pacemaker Control of Ventricular Tachyarrhythmias" by Dr. Benjamin L. Plybon; and "Unusually Marked Sinus Arrhythmia as a Complication of Acute Diaphragmatic Myocardial Infarction" by Dr. Edwin J. Morgan.

Twenty-six members attended the meeting.—W. Gene Klingberg, M. D., Secretary.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324

AAP Announces Program For Annual Meeting

In-depth presentations on child care—a national challenge, new considerations in the diagnosis and management of neonatal jaundice, key issues in infant mortality, multiphasic screening for pediatric patients, and current developments in objective means of diagnosis and therapy in allergic disorders, will be discussed during the 38th Annual Meeting of the American Academy of Pediatrics in Chicago, October 18-23.

More than 4,500 persons including pediatricians, their families and guests are expected to attend the meeting in the Palmer House Hotel.

Additional timely scientific subjects will be presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, Public Health Pediatrics, and Surgery.

The meeting will also feature numerous seminars, round tables, and a full schedule of motion picture films.

A special one-day conference for pediatricians and pediatric nurses will also be held during the annual meeting. This conference will enable pediatricians and nurses to discuss cooperative approaches and potential programs for meeting patient care needs.

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Book Reviews

INTERNAL MEDICINE IN WORLD WAR II, VOLUME III—By Colonel Robert S. Anderson, MC, USA, Editor in Chief and W. Paul Havens, Jr., M. D., Editor for Internal Medicine and by the Medical Department, United States Army, Washington, D. C. Volume III, First Edition. 1969. Pp. 712. Illustrated. Price $8.25.

This volume is the third and last in that Medical Series reporting on the experiences of the U. S. Army Medical Department with Internal Medicine in World War II. The preceding volume discussed infectious diseases met with in a global war.

This last volume could be called a "Global Text Book of Internal Medicine." There are many diseases included in the text and described, about which little or nothing was known before the war. The foreword mentions "Bullis Fever", a tickborne illness, as an example. A cardiologist of any age would be aroused by H. B. Sprague's report that plasmodium falciparum can cause death from myocardial inflammation or capillary thrombosis. W. C. Merkel, known personally to me, reports two cases of death resembling coronary thrombosis where at autopsy there was found a widespread obstruction of the coronary vessels by the parasites of falciparum malaria.

The section on malnutrition in the "Far East" is of interest and likewise the large section devoted to dermatology. Most all medical officers serving overseas are familiar with combat fatigue and in a special section devoted to psychosomatic medicine this state is beautifully described and quotes Ernie Pyles' description from "Here Is Your War."

The section on the Ramp Story—Story of Imprisonment—is complete, including nutritional disorders, forced labor, physical mistreatment, poor or no medical care and the total disregard of the Geneva Convention by all of our enemies. Ramp is "Recovered Allied Military Personnel." This volume is one of the most interesting of the series. It is of the utmost importance as a text-reference book and history in our times.

This volume is most highly recommended. It exhibits 21 chapters, 123 illustrations, eight charts, and 105 tables. Illustrations, black and white and in color, all are excellent. It is truly a library volume.—C. Frederick Fisher, M. D.

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AVAILABLE—Board eligible general surgeon upon completion of training on June 30, 1969. Filipino, married, with ECFMG Certificate. Presently Chief Resident, finishing the fourth and final year of training in a Type I residency program. Write: Rafael E. Saladar, M. D., Illinois Central Hospital, 5800 Stony Island Ave., Chicago, Illinois 60637.

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AVAILABLE—General surgeon upon completion of training in July 1969. Filipino, married, with ECFMG Certificate. Presently doing preceptorship to complete board requirements. Write: Roberto B. De Ocampo, M. D., 40 Prospect Avenue, Norwalk, Connecticut 06850.

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OCTOBER
1969

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Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1969

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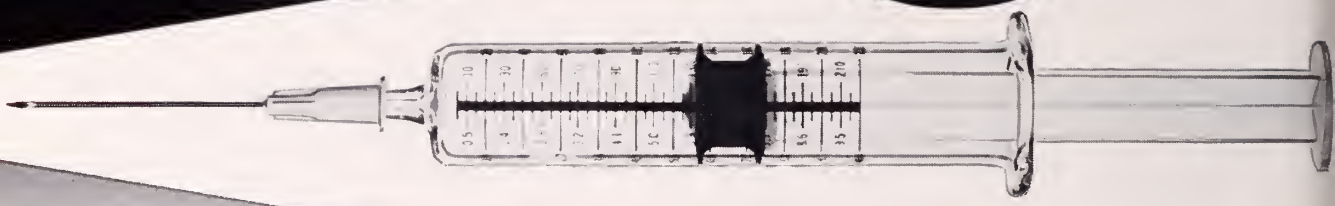

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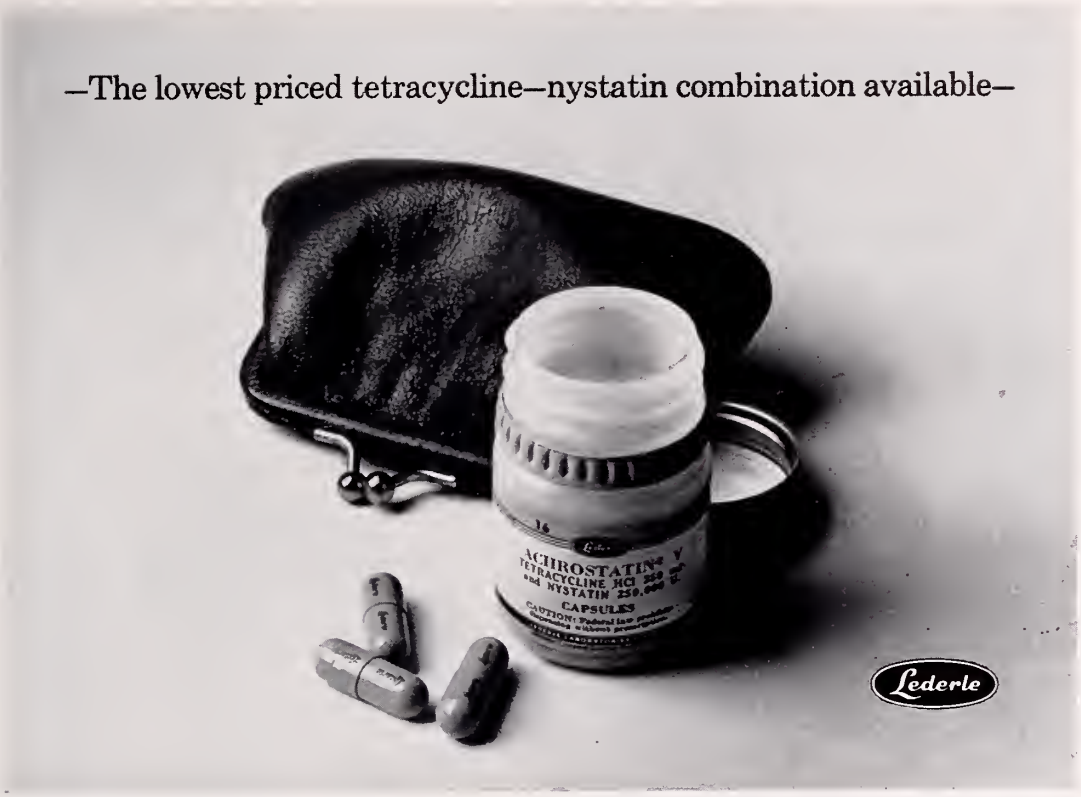

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WVU Medical Center
—News—

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Several persons have received faculty appointments in the School of Medicine in recent weeks. They are as follows:

Marianne Angert, Assistant Professor of Medical Technology; Marion K. Aronwitz, Assistant Professor of Psychiatry (psychology); Dr. Reza Asli, Instructor in Surgery (neurosurgery); Dr. Anthony Parke Avery, Instructor in Surgery (otolaryngology); Dr. Magdi S. Azer, Clinical Assistant Professor of Surgery; Dr. James F. Carruth, Clinical Professor in Psychiatry (psychology).

Stuart T. S. Chen, Assistant Professor of Medicine (gastroenterology); Dr. Philip E. Comer, Clinical Assistant Professor in Psychiatry (psychology); Dr. Forest A. Cornwell, Clinical Associate Professor in Pediatrics; Dr. Morton H. Friedman, Instructor in Anatomy; Dr. Tristan M. Gale, Instructor in Radiology; Dr. Irving J. Goodman, Clinical Assistant Professor of Psychiatry (psychology).

Nancie Ann Graham, Instructor in Medicine and Medical Technology (metabolism and endocrinology); Dr. David S. Hall, Assistant Professor of Medicine (public health and preventive medicine); Dr. Trevelyn Hall II, Instructor in Surgery (otolaryngology); Dr. Edward E. Hill, Assistant Professor of Biochemistry; Beatrice R. Hunter, Clinical Instructor in Psychiatry (social work); Dr. Alfred Jacobs, Clinical Professor of Psychiatry (psychology).

Dr. Thomas H. Joyce III, Assistant Professor of Surgery (anesthesiology); Dr. Chong J. Kim, Clinical Instructor in Radiology; William J. Kraus, Clinical Instructor in Medicine (public health and preventive medicine); Lauren M. Kullman, Instructor in Medical Technology; Dr. Irwin L. Lunianski, Clincial Instructor in Psychiatry; Dr. Thomas W. McIntyre, Assistant Professor of Physiology and Biophysics.

Dr. Roderick A. Malone, Assistant Professor of Surgery (anesthesiology); Robert K. Nauman, Instructor in Microbiology; Dr. Lester L. Ourth, Clinical Associate Professor of Psychiatry (psychology); Joseph V. Panepinto, Clinical Associate Professor of Psychiatry; Harold L. Pearson Jr., Instructor in Surgery; Patricia B. Porterfield, Instructor in Psychiatry (social work).

Dr. Robert S. Salisbury, Instructor in Pathology; Phyllis V. Spiker, Instructor in Medical Technology; Rebecca A. Supler, Instructor in Surgery (otolaryngology); Dr. Masaharu Takamori, Assistant Professor in Neurology; Dr. Havelock Thompson, Associate Professor in Pediatrics; Dr. Alptekin Ucmakli, Assistant Professor in Radiology; Ida I. Yoder, Instructor in Medical Technology; and Dr. Raymond D. Zinn, Professor of Medicine (public health and preventive medicine).

New Administration Trainee

Mr. John Tiano arrived in Morgantown on August 1 to begin a year as an administrative resident at West Virginia University Hospital. A native of Clarksburg, Mr. Tiano is enrolled in the University of Minnesota's graduate program in hospital administration. He received a B.S. degree in pharmacy from WVU in 1957.

Psychologists Present Papers

Several members of the faculty of the Department of Physiology and Biophysics are authors of scientific papers which were presented August 25-29 at the 20th Annual Meeting of the American Physiological Society at the University of California in Davis.

The presentations were made by Martin J. Fisher, Dr. Ishio Ninomiya, and Dr. Michael F. Wilson, Department Chairman. Other authors are Dr. Kenneth C. Weber, William V. Judy, W. Morton Caldwell and Dr. Gunter N. Franz.

The papers were entitled "Determination of Alveolar Surface Area and Surface Tension as a Function of Volume in the Cat Lung from in Situ Pressure-Volume Measurements," "Sympathetic Nerve Activity in Unanesthetized Cats," and "Interaction of Posterior Hypothalmic Stimulation and Baroceptor Reflexes on Renal Nerve Activity."

Doctor Kenny Returns

Dr. Alexander D. Kenny, former Professor of Pharmacology at WVU, returned to the Medical Center on August 27 to present a seminar entitled "Pharmacological Studies of Bone Resorption." His visit was sponsored by the Department of Medicine's Division of Metabolism and Endocrinology.

Doctor Kenny is now Professor of Pharmacology at the University of Missouri School of Medicine.

Emergency Care Course Conducted

The School of Medicine conducted a course in emergency care and transportation for the injured and seriously ill at the Medical Center, September 23-24. Classes were held each day and demonstrations and practical work was scheduled during the evening hours.

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W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

A Food and Drug Administration advisory committee found oral contraceptives to be "safe," but reported that British and U.S. studies had established "an etiologic relation between thromboembolic disorders" and their use. The Advisory Committee on Obstetrics and Gynecology, making its second report on oral contraceptives, said that their benefits outweighed the risks sufficiently to designate them "safe" within the intent of the federal law.

As for the potential carcinogenity of oral contraceptives, the report said no conclusion could be drawn at this time.

The committee called for intensive research along three lines: (1) possible relationship of hormonal contraceptives and carcinoma of the breast and uterus; (2) determination of the basis and prognosis of metabolic alterations produced by hormonal contraceptives; and (3) development of new methods of contraception.

The committee, in its initial report three years ago, approved of oral contraceptives with reservations. It now said that these reservations appear to have been justified because of the adverse reactions reported in both scientific literature and the general press. But the report concluded:

"When these potential hazards and the value of the drugs are balanced, the committee finds the ratio of benefit to risk sufficiently high to justify the designation safe within the intent of the legislation (Kefauver-Harris Amendments of 1962)."

The report said scientific studies "suggest that the mortality from thromboembolic disorders attributable to the oral contraceptives is about three per 100,000 women per year." In a U.S. study, the risk of thromboembolism to a woman using hormonal contraceptives was estimated by indirect methods to be 4.4 times that of a non-user.

The effectiveness of oral contraceptives was found to be significantly higher than for intrauterine devices or traditional methods.

IRS Decision

Abandoning a long court fight, the Internal Revenue Service reversed itself and ruled that organizations of physicians authorized under state professional association laws will be treated as corporations for tax purposes.

• **From the Washington Office of the American Medical Association.**

The IRS announced that it would not appeal to the Supreme Court two recent decisions by U.S. courts of appeal favoring the professional association. In accordance with these court decisions, the IRS said, "organizations of doctors, lawyers and other professional people organized under state professional association acts will, generally, be treated as corporations for tax purposes."

Forty-two states have such laws which offer tax benefits, including deferment of the tax on pension plan contributions until retirement.

Physician Augmentation Program

The federal government has started a program designed to increase enrollment in the nation's schools of medicine and osteopathy, by 4,000 over the next four years.

Known as the Physician Augmentation Program, the activity, under the Department of Health, Education and Welfare, supports the addition of 1,000 first year places commencing with the fall term of 1970. These places are in addition to any increase to which the schools have already committed themselves. Total enrollment through this program is expected to be about 4,000 in the fourth year of operation. The Physician Augmentation Program is authorized under the Health Manpower Act of 1968.

Grants will be awarded on a national competitive basis to those schools of medicine and osteopathy that document their intention to institute a major increase in their first-year enrollment and that appear to have the greatest potential for achieving major increases with their own resources as supplemented by funds allocated by the program.

Medicaid Cost Control

Robert H. Finch, Secretary of Health, Education and Welfare, proposed that state Medicaid administrators work more closely with state medical societies on cost control in the federal-state health care program. He also said that the states should review more claims in efforts to control Medicaid costs.

Mr. Finch gave his views on controlling Medicaid costs in a letter to Sen. Abraham Ribicoff (D., Conn.) who had asked what was being done and what additionally could be done about rising expenditures in the program.

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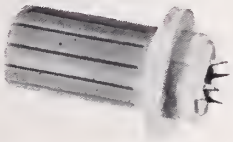

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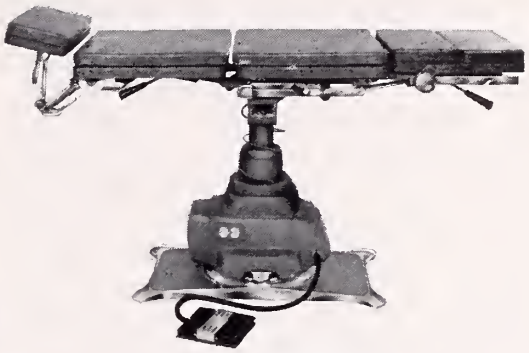

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Annual Reports *

Committee on Presidential Address

It has long been the custom for your retiring President to use his annual address as a means of reporting his hopes, thanks and accomplishments to his constituency.

In his annual address, Doctor Corbitt has evinced the proper spirit of humility which sooner or later beshrouds every President at some time during his tenure of office. The first half of his address has been devoted to individual and group thank-yous and appreciation for services rendered to organized medicine at the local and state levels. His mode of expression is definite evidence of an appreciative leader whose efforts, if he is to enjoy a productive year, must be supported by those appointed to committee membership.

For those members who do not have the occasion or desire to engage actively in the inner political aspects of organized medicine, Doctor Corbitt's description of the election of one of our members to high office in the American Medical Association is a vivid portrayal of the wheels within wheels which must operate in a well-oiled manner if any individual is to be nationally recognized for his ability and determined dedication to service. Every individual concerned in this victorious effort is to be thanked and congratulated.

It is good to have Doctor Corbitt's report on his official visits to the annual medical meetings in our neighboring states. These visits are always pleasant and mutually rewarding.

Doctor Corbitt's remarks regarding the social and political aspects of our health care system are well taken and worthy of serious consideration and activity on the part of all members. Your Committee is particularly impressed by his statements in reference to the physician shortage in our State and the means, both at present and in the future, which he recommends in the furtherance of this estimable project. It is of vital importance that we maintain a close and constant liaison with these future physicians.

Your Committee feels that Doctor Corbitt should be recognized as a conscientious and working-type of leader and recommends a standing vote of thanks for his year-round devotion to our needs and our general welfare.

Respectfully submitted,

James S. Klumpp, M. D.
Chairman

August 23, 1969.

*Other annual reports were published in the August 1969 issue of The Journal.

Sub-Committee on Joint Commission On Accreditation of Hospitals

Your Sub-Committee has met on two occasions to discuss the proposed Standards for Accreditation of Hospitals. In addition, two members of the Sub-Committee have attended two meetings in Chicago, where representatives of state medical societies, state hospital associations and the JCAH were called to discuss the provisional draft of the Standards.

As a result of these two meetings and the discussions they engendered, a modified provisional draft of the proposed standards was evolved and again submitted to state medical and hospital associations for comment. Because of the furor caused by the proposed standards, your Committee directed letters of inquiry to the chiefs of staff and administrators of all the hospitals in West Virginia asking for comments on, and grievances against, the JCAH and its field inspectors. Ten letters were received in response to this request, the majority of which either had no criticisms to make or had not experienced a survey. Of those who made comments, the major problem talked about was the lack of uniformity of the inspectors in applying the current standards and their failure to consider the size of the hospital's medical staff in their demands for compliance with the standards already in existence. Your Sub-Committee, however, wishes to emphasize that part of its charge is to receive, evaluate and pass on to the JCAH any grievances which hospital medical staffs have or may in the future develop concerning any JCAH inspector or team or any injustices the staffs feel may have occurred during any survey.

After thorough review of the new provisional draft of the Standards for Hospital Accreditation, published early in July, 1969, your Sub-Committee can find only minor errors of commission and omission in the draft proposals. We believe the Standards and their interpretations are sufficiently broad and flexible that all hospital medical staffs and administrators can live with them successfully and relatively easily. The Standards may be a little too restrictive in the fields of nursing services, pathology services and pharmaceutical services, but experience after January 1, 1970, will be needed before this can be determined. Your Committee therefore recommends general acceptance of the proposed Standards and compliance with them insofar as feasible for the size of the hospitals screened.

One word of caution should be inserted here. The West Virginia State Medical Association passed a resolution requesting the AMA to support a demand that one or more physicians be placed on the Board of Trustees of every hospital. Similar resolutions were presented by other states. The American Hospital Association strongly opposed such a requirement by the JCAH. Their reasoning should be understood by all physicians. The AMA position does not preclude membership of a physician on the hospital Board if he meets all qualifications for trusteeship. It is, however, against the insistence that a physician be placed on the Board who has been elected by the organized

medical staff. They point out that there is a question as to the propriety of making a physician a voting member of the body that grants him hospital privileges, that to allow the medical staff to designate one or more members of the Board raises the question of group representation of special interests and opens the probability of the necessity of allowing other groups, such as labor unions, representing hospital employees, banking interests handling hospital accounts, and legal groups representing the hospital before local, state and federal courts, to elect members to the Board. The proposed Standards state "no hospital by its organizational make-up or by policy, should deny governing body membership to physicians." Your Committee believes this is a reasonable approach to the current situation and probably the best your Association can expect.

Respectfully submitted,

Richard V. Lynch, Jr., M. D.

August 20, 1969.

Report of Special Committee Named To Study and Evaluate the Scholarship Program

During the 101st Annual Meeting of the West Virginia State Medical Association, held at The Greenbrier in White Sulphur Springs, August 21-24, 1968, the House of Delegates adopted a resolution which authorized and instructed the President of the Association to appoint a Special Committee to Study and Evaluate the Scholarship Fund of the Association. The Committee appointed by the President was instructed to present its recommendations to the House of Delegates during the 1969 Annual Meeting as to the future course of the program.

On November 8, 1968, Dr. Richard W. Corbitt, the President, appointed the following physicians to serve as members of the Special Committee:

Dr. Kenneth G. MacDonald of Charleston, Chairman; Dr. Robert W. Bess, Jr., of Piedmont; Dr. F. Lloyd Blair of Parkersburg; Dr. J. C. Huffman of Buckhannon; Dr. Thomas P. Long of Man; and Dr. Stephen D. Ward of Wheeling.

Following preliminary study, your Chairman issued a call for a meeting of the Special Committee to be held at The Daniel Boone Hotel in Charleston on March 2, 1969. Invited to attend the meeting were members of the Scholarship Committee and other interested physicians. Following several hours of discussion, it was the consensus of those present, that the following recommendations should be presented to the House of Delegates:

(1) The Association should continue the policy of awarding annual scholarships, worth $4,000 each to two first-year students enrolled in the West Virginia University School of Medicine.

(2) The agreement between the Scholarship Committee and the recipients of the scholarship awards should be amended by deleting the requirement that the recipients shall "engage in the practice of medicine for a period of four years in a rural community located within the State of West Virginia and approved by the Scholarship Committee." A new contract should be drafted to require the recipient to practice anywhere within the boundaries of West Virginia for a period of four years in order to fulfill the obligations of his contract with the West Virginia State Medical Association.

(3) It was agreed the Scholarship Committee should contribute a sum not to exceed $5,000 from reserves in the Charles Lively Memorial Scholarship Fund to the West Virginia University Foundation. Such funds would be matched on a nine to one basis, with funds available from the federal government, and would enable medical students to obtain short-term loans to help meet financial emergencies that might arise. Also, it should continue to be the policy that loans from the Fund be made to only medical students who are bona fide residents of the State of West Virginia and that students be informed by the Chairman of the Medical School Committee on Student Welfare of the source of the funds from which the loan was made.

The Special Committee was aware that two previous contributions of $4,000 each had been made by the Association to the WVU Foundation in recent years. We were informed that this revolving fund has served a highly useful purpose.

Finally, the same conditions governing the administration of the present revolving fund should be followed in connection with future contributions which may be made by the Association.

Respectfully submitted,

Kenneth G. MacDonald, M. D., *Chairman*
Robert W. Bess, Jr., M. D.
F. Lloyd Blair, M. D.
J. C. Huffman, M. D.
Thomas P. Long, M. D.
Stephen D. Ward, M. D.

August 20, 1969.

Syphilis Committee

Members of the Syphilis Committee and special guests met at the Daniel Boone Hotel in Charleston on May 7, 1969, for a dinner meeting.

Those present were: Dr. N. H. Dyer, Chairman; Members: Drs. Thomas L. Thomas, Wheeling; Lyle D. Vincent, Parkersburg; Isaiah A. Wiles, Morgantown; Guests: Drs. Charles E. Andrews, Morgantown; Blonda S. Brake, Clarksburg; Messrs. Ronald G. Bryant and John R. Shomo, Charleston.

Following dinner, Doctor Dyer opened the business portion of the meeting and presented each person with a packet of materials entitled "Venereal Disease Literature for Physicians." The packet contained several publications concerning recent developments in the diagnosis and treatment of venereal disease. The 1968 National Survey of Venereal Disease Incidence, Public Health Laws pertaining to the treatment of

minors infected with venereal disease, and the 1969 edition of "Today's Venereal Disease Control Problem" were also enclosed. Specific information pertaining to the 1968 Incidence Study and Public Health Laws had been mailed to members for their review prior to the meeting.

The discussion immediately focused on the effects both pro and con which Public Health Laws pertaining to examining and treating minors infected with venereal disease have on the current venereal disease problem. Most members felt that the Public Health Law which required West Virginia physicians to notify the parents of minors treated for VD was curtailing the efficiency of the venereal disease control program and was attributing to the present VD problem among teenagers and young adults.

The fact that 37 states presently empower the health department and private physicians to examine and treat persons of any age suspected of having a venereal disease and since 30 per cent of all infectious venereal disease cases reported in West Virginia during 1968 was identified among young persons under age 20 and 70 per cent under age 25, the Committee recommended that action be taken to cause the Interim Committee of the State Legislature to study this problem and make recommendations accordingly.

During the aforementioned discussion, the need for presenting the true facts about venereal disease through the educational system was noted and the Committee recommended that the State Medical Association endorse the following recommendation which is listed on Page 7 of the 1969 edition of "Today's VD Control Problem," a Joint Statement by the American Public Health Association, the American Social Health Association, the American Venereal Disease Association with the cooperation of the American Medical Association, the American Osteopathic Association, the Association of State and Territorial Health Officers, and the National Medical Association. During 1968 seven of every ten infectious cases of venereal disease reported to the West Virginia State Department of Health was identified in persons under age 25 which placed West Virginia 19 percentage points above the national average.

The recommendation states: "THAT, in view of the fact that statistics indicate an average of one VD infection in every 200 teen-agers (ages 15-19) in the United States, state and local departments of education consider VD education for teen-agers as an urgent need; that colleges preparing teachers include instruction in VD education in their curricula; and that state and local health departments provide assistance to schools and colleges in the furtherance of these programs."

The 1968 National Survey of Venereal Disease Incidence conducted from April through July, 1968 revealed that 892 West Virginia physicians responded to the survey questionnaire and that 39 per cent of them treated a total of 1,182 cases of infectious venereal disease during the study period. It also showed that less than eight per cent of these cases were reported to the State Department of Health. Using these figures, the survey estimated that during fiscal year 1968, private physicians in West Virginia treated over 5,800 infectious cases of venereal disease but reported only 436 cases.

Members of this Committee agreed that the success of the venereal disease control program is dependent on reporting. The following recommendation was read from Page 6 of "Today's VD Control Problem."

The recommendation states: THAT physicians in private practice accept their responsibility for the prevention of the spread of VD. Findings of the National Survey of VD Incidence documented the fact that three-fourths of all cases of VD are now treated in the office of the private physician, and that private physicians report an average of only one in eight cases treated by them. Further, THAT private physicians accept guidance and direction from their professional societies to participate fully in the VD control program."

During the meeting West Virginia's venereal disease program activities were discussed and it was made known that infectious cases of syphilis decreased by 68 per cent during 1967 and 1968, but during this same time gonorrhea cases increased 417 per cent. Studies are being conducted to determine the prevalence of the asymptomatic female gonorrhea patient. To date 208 cases have been identified among the 2,901 women tested. Limited studies are also being conducted to determine the effect of various approaches to performing epidemiology around gonorrhea patients.

The need for obtaining routine serologies for all hospital and private practice admissions was emphasized. Most of the 1,291 case of late and late latent syphilis reported in 1968, which ranked West Virginia sixth in the nation with a case rate of 64.2 per 100,000, were brought to treatment as a result of follow-up conducted for reactive serologies.

The venereal disease control program continues to place major emphasis on casefinding and case prevention through the application of epidemiology, however additional emphasis has been given to venereal disease education and awareness programs. Over 700 programs were presented in 1968 to some 45,000 persons. Civic organizations and education systems have become actively engaged in bringing valid venereal disease education to residents of both urban and rural communities. It is a known fact that the silent treatment has never and will never cure a single case of venereal disease.

Respectfully submitted,

N. H. Dyer, M. D.
Chairman

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1968

Sept. 8—R. DeWitt Peck ..... Montgomery
Sept. 10—Horace M. Banks ..... Indianapolis
Sept. 15—J. S. Skaggs ..... Charleston
Sept. 28—Arthur W. Higgins ..... Wheeling
Oct. 21—Francis Alden Clark ..... Charleston
Oct. 26—Walter Leigh Barbour ..... Parkersburg
Nov. 6—Benjamin M. Stout, Jr. ..... Morgantown
Dec. 16—P. R. Fox ..... Bluefield
Dec. 22—Edward D. Gibson ..... Lighthouse Point, Fla.
Dec. 29—Homer D. Martin ..... Dailey

1969

Jan. 19—Claude A. Thomas ..... Martinsburg
Jan. 22—Charles L. Wilbar, Jr. ..... Morgantown
Feb. 7—Jay Bigelow Bailey ..... Davy
Feb. 23—Harold G. Young ..... Morgantown
Apr. 13—Harry Dixon Law ..... Charleston
Apr. 20—Raymond A. Updike ..... Montgomery
Apr. 26—Carl Chester Romine ..... Morgantown
Apr. 28—Helen Merwin Wiestling ..... Wheeling
May 5—William E. Wilkinson ..... Beckley
May 21—Edwin B. Thompson ..... Montgomery
May 25—Earle L. Shamblen ..... Charleston
June—Harry Stanley Keister ..... Fairmont
June 13—William M. Riley ..... Mabscott
June 23—Karl H. Trippett ..... Grafton
June 29—William J. Smith ..... Belfry, Ky.
July 23—Samuel C. Dotson, Jr. ..... Morgantown
July 31—Louis B. Farri ..... Wheeling

Respectfully submitted,

William H. Lively,
Executive Secretary

August 20, 1969.

Comprehensive Health Planning Reviewed in New Document

The goals, priorities and problem areas of comprehensive health planning are reviewed in a new document issued by the Health Insurance Council.

Entitled "Community Health Action-Planning—Problems and Potentials," the 22-page publication is designed as an introductory guide to planning for business and professional leadership involved in state and community health activities.

Included is information on the history of health planning, key provisions of planning legislation, suggested organization and relationship of health agencies within a state, criteria for effective areawide planning agencies, priority actions to be taken by agencies, and barriers that may be encountered.

In a concluding summary, the author, David Robbins, Controller and Director of Statistic, Health Insurance Association of America, urges a concerted effort by business executives to help solve the problems of health facilities, services, manpower and environment.

Resolutions

One resolution offered at the first session of the House of Delegates on Wednesday afternoon, August 20, 1969, was referred to the Committee on Resolutions for study and report back with recommendations at the final session on Saturday afternoon, August 23.

Dr. Richard E. Flood of Weirton, the Chairman, presided at the meeting of the Committee on Thursday afternoon, August 21. Other members of the Committee participating were Drs. Seigle W. Parks of Charleston and Albert C. Esposito of Huntington and Mr. William H. Lively of Charleston, secretary ex officio.

The following report was submitted by Doctor Flood and approved at the final session of the House of Delegates:

Your Committee on Resolutions carefully considered the one resolution offered before the first session of the House of Delegates on Wednesday afternoon, August 20, 1969.

We are happy to report that several interested physicians appeared at a meeting of the Committee held on Thursday afternoon, August 21, 1969, and discussed in detail the one resolution pending before the Committee.

The cooperation of these physicians has been most helpful to the Committee in reaching a decision, and we express appreciation to those who took time to attend the open hearing to discuss the following proposed resolution:

Resolution No. 1. The Scholarship Fund of the West Virginia State Medical Association. By the Special Committee Named to Study and Evaluate the Scholarship Program of the West Virginia State Medical Association.

WHEREAS, The House of Delegates, at the annual meeting of the Association, unanimously adopted Resolution No. 1, entitled, "Medical Scholarships", on August 24, 1957; and

WHEREAS, The Association is desirous of amending such Resolution to delete all reference to "rural practice",

THEREFORE, BE IT RESOLVED, (1) That Resolution No. 1, entitled, "Medical Scholarships," adopted by the Association August 24, 1957, be and the same hereby is amended by deleting therefrom the word, "rural" in each instance in which such word appears in such Resolution; and (2)That in all other respects, said Resolution remain in full force and effect, and

BE IT FURTHER RESOLVED, That the form agreement executed between the Medical Scholarship Committee of the West Virginia State Medical Association, and the recipient of such scholarship award, be amended to conform to this Resolution, and that the words, "Medical Scholarship Committee' be substituted for the words, "Committee on Rural Health" in sub-paragraph 3, of paragraph 1, of said Resolution, and

BE IT FURTHER RESOLVED, That paragraph 2. of said Resolution be deleted.

Obituaries

WILLIAM JAMES GLASS, SR., M.D.

Dr. William J. Glass, Sr., died on August 31 at his home in Sissonville in Kanawha County at the age of 90.

A native of Mason County, Doctor Glass continued to see patients until a few weeks before his death. He received his M. D. degree from the University of Louisville School of Medicine in 1907 and began practice that year in Sissonville.

In 1958, Doctor Glass was honored as "General Practitioner of the Year" at the Annual Meeting of the West Virginia State Medical Association.

The veteran physician was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Pearl Milam Glass; a daughter, Mrs. Gwyndolia Bock of Charleston; sons, Dr. William J. Glass, Jr., of Monett, Missouri, and Dr. Olin Carter Glass of Sissonville; a sister, Mrs. Ann Shreve of Fairmont; and a brother, George Glass of Charleston.

EDWARD ANDREW LITSINGER, M.D.

Dr. Edward A. Litsinger, 67, of Ripley, died in a hospital in that Jackson County community on September 7.

Doctor Litsinger attended Randolph Macon College in Virginia and West Virginia University before receiving his M.D. degree from the University of Maryland School of Medicine in 1928.

He was engaged in practice in Charleston for a time and for eight years he served as Superintendent of Spencer State Hospital.

He was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. He also was a member of the American Psychiatric Association.

Survivors include the widow, Mrs. Virginia Litsinger; daughters, Mrs. Thomas R. Poole of Charleston and Mrs. Lawrence H. Young, Jr., of Charleston; a son, Charles G. Litsinger of Ripley; sisters, Mrs. Robert Kain of Miami Beach, Florida, and Mrs. Frank Gregory of Thousand Oaks, California; and a brother, George A. Litsinger of Ripley.

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Correspondence

WEST VIRGINIA UNIVERSITY
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Dear Mr. Lively:

The special contribution of $5,000, transmitted to me as Dean of the West Virginia University School of Medicine during the 1969 meeting of the West Virginia State Medical Association, comes at a most propitious time. We wish to take this means to express the most sincere appreciation of all of us here at the School to all the members of the State Medical Association who have made this contribution possible. Particularly, present and future "generations" of students are and will be most appreciative of this assistance.

It is our understanding that the $5,000 forwarded upon the recommendation of the State Medical Association's Committee on Scholarships is to be used as matching money to make possible our maximum participation in the Federal 9 to 1 matching loan program.

In the present year, when total Federal support for medical student loans has been reduced drastically, it is especially gratifying that we will have available matching money to enable us to participate to the extent of our full authorization.

Again, our most sincere thanks to all members of the Association.

Very truly yours,

/s/ Clark K. Sleeth, M.D.
Dean

* * * *

WEST VIRGINIA CHAPTER
STUDENT AMERICAN MEDICAL ASSOCIATION

Dear Mr. Lively:

As President of the Student American Medical Association at West Virginia University, I take this opportunity to thank all the members of the West Virginia State Medical Association in behalf of the present and future medical students at West Virginia University for the special contribution of $5000.00 which we understand is to be used in the federal matching fund and specifically designated for West Virginia residents. This contribution will be especially helpful at this time when federal funds for medical students have been drastically cut.

Again, in behalf of the medical students of West Virginia University School of Medicine, I thank the entire State Medical Association.

Sincerely yours,

/s/ Deleno H. Webb, III
President

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Heart Association To Publish New Journal on Stroke

The American Heart Association has announced that it will publish a new scientific periodical entitled "Stroke—A Journal of the Cerebral Circulation." January, 1970 has been scheduled as date of the first issue. The journal will appear bi-monthly thereafter.

The first scientific journal concerned with stroke, it will be of interest to practicing physicians—especially internists, cardiologists, and neurologists—as well as teachers, clinical investigators and laboratory scientists. Articles will include clinical conferences and will be concerned with prevention, diagnosis, treatment and rehabilitation. Research will also be reported in the fields of vascular physiology, pathophysiology, epidemiology, neuro-ophthalmology, radiology and surgery.

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Vol. 65 No. 11

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Official Organ of the West Virginia State Medical Association

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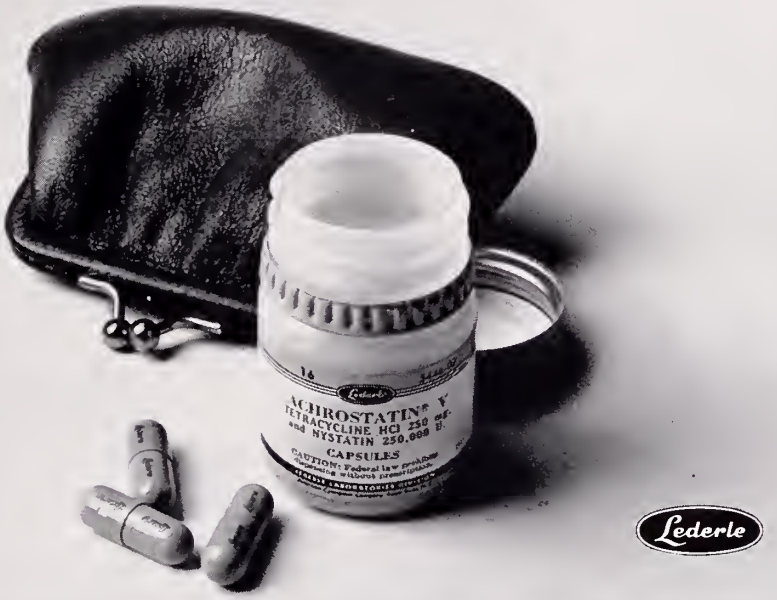

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WVU Medical Center
—News—

THE appointment of Dr. Milton R. Hales as Chairman of the Department of Pathology in the School of Medicine has been announced by WVU President James G. Harlow.

The appointment was effective September 1. Doctor Hales succeeds Dr. Wilhelm S. Albrink, who resigned but remains on the faculty as Professor of Pathology.

Milton R. Hales, M. D.

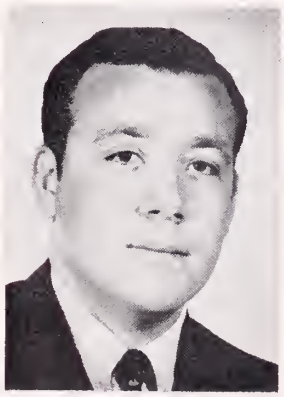
Doctor Hales joined the Department with the rank of Professor on June 1, 1968. He had served as Associate Professor of Pathology at Yale University. He received his M. D. degree at the University of Southern California School of Medicine.

Doctor Hales served internships at Los Angeles County Hospital and at New Haven Community Hospital in Connecticut. He completed his pathology residency at the latter institution.

The new Chairman's research interests and activities center mainly on diseases of the liver, particularly the associated vascular changes. He is a Diplomate of the American Board of Pathology and is a member of the Association of American Pathologists and Bacteriologists.

New York Life Scholar

Mr. Robert L. Hively, a first-year medical student from Kanawha County, has been named West Virginia University's fourth New York Life Insurance Company Medical Scholar.



Robert L. Hively

The four-year scholarship is renewable annually upon the School's determination of satisfactory academic performance. It provides funds for tuition, books, housing, board and equipment.

Mr. Hively completed his pre-medical studies at Morris Harvey College. He is the son of Mr. and Mrs. Roy D. Hively of Elkview and is married to the former Minnie Carr of Dunbar.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

WVU is one of 11 schools the New York Life Insurance Company chose in 1966 to begin its medical student scholarship program. Three other New York Life scholars currently are attending the WVU Medical School.

Laboratory Cited for Excellence

WVU Hospital Clinical Laboratories recently received a certificate of recognition for excellence of performance in participation in the 1969 Survey Program of the College of American Pathologists.

After providing samples of unknowns for the voluntary blind studies on which technologists in the participating hospital laboratories run the necessary tests and report their results, the College evaluates performances in hematology, blood bank, coagulation, microbiology, serology, clinical microscopy and chemistry.

"I'm very pleased at the fine ratings achieved by our technologists, and also that our microbiology laboratory is designated as a referee in the survey," Dr. Vincente Anido, Director of Clinical Laboratories, remarked.

Lecture on Diabetes

Dr. Holbrooke S. Seltzer of Dallas, Texas, one of the nation's leading authorities on diabetes, lectured at the Medical Center on September 12.

He presented a paper on "Insights About Diabetes Gained from Insulin Assay." Doctor Seltzer is Chief of the Endocrinology Section, Department of Medicine, Veterans Administration Hospital, Dallas.

Doctor Chang Lectures Abroad

Dr. C .H. Joseph Chang, Professor and Acting Chairman of the Department of Radiology, presented a paper at the 12th International Congress of Radiology in Tokyo last month.

His topic was "The Chest Film in Pulmonary Hypertension." Before his return to Morgantown, Doctor Chang also gave an invitational lecture at Yonsei University College of Medicine in Seoul, Korea.

Immunologists Elect Dr. Wirtz

Dr. George A. Wirtz, Associate Professor of Biochemistry, recently was elected to membership in the American Association of Immunologists. The Association is an organization of persons who, on their own, have contributed significantly to the field of immunology and who are most likely to continue such contribution.

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The Month in Washington

• From the Washington Office of the American Medical Association.

HEALTH, Education and Welfare Secretary Robert Finch has asked a special Task Force on Medicaid to examine and make recommendations on proposals for a sweeping national health program. The Task Force, headed by Walter J. McNerney, President of the Blue Cross Association, is scheduled to issue a report about the first of the year.

After referring to a proposal for universal health insurance endorsed by many governors at the National Governors' Conference, Finch told McNerney in a letter:

"I would like specifically to request that the Task Force consider, along with its other deliberations on Medicaid and related programs, what directions and initiatives you feel the HEW Department should pursue in this area."

According to McNerney, one phase of the study would include the extension of Medicare to persons of all ages, roughly the national compulsory health plan backed by Walter Reuther of the United Auto Workers and his Committee of 100 for National Health Insurance.

McNerney, however, also said that all types of mass plans would be studied, including the health insurance tax credit proposal endorsed by the American Medical Association.

The rapidly rising costs of Medicare and Medicaid have brought the issue to the forefront. The Administration said older people who enter the hospital after January 1 will have to pay for an additional $8 of their hospital bills due to the higher costs. The increase is required by law.

The benefit cutback results from an adjustment of the portion of the hospital bill for which a Medicare beneficiary is responsible if these costs have risen substantially.

Disjointed Bureaucracy

After a two-year study, Sen. Abraham Ribicoff (D., Conn.), former HEW Secretary, said he's reached the conclusion the federal health effort "is a planless conglomeration of programs administered by more than a score of agencies and departments."

Federal health spending "instead of supporting programs to provide for the health of the people . . . is maintaining a cumbersome, disjointed bureaucracy that even key government officials have difficulty managing," he told the Senate.

"Instead of eliminating problems, (they) may be adding to factors such as rising costs, limited access to care and the fragmented organization of health services."

"There are so many programs administered in such bureaucratic confusion that no one—not the HEW Department, not the Bureau of the Budget nor any private organization was able to tell the subcommittee even how many programs there are."

Alcoholism and Drug Dependence

The American Medical Association told Congress drug dependent persons should be treated as patients rather than criminals.

In testimony before the Senate Juvenile Delinquency Subcommittee, Henry Brill, M.D., Chairman of the AMA's Committee on Alcoholism and Drug Dependence, said physicians are concerned over legislation before the Subcommittee proposing harsher penalties for persons unlawfully possessing drugs for their personal use.

"Mere possession for personal use of depressant and stimulant drugs having a legitimate medical usage should not constitute an offense," Doctor Brill said. "The degree of social hazard and the reasons for having the drug should be taken into account."

"With respect to the entire section on offenses and penalties, we propose an amendment to direct courts to appoint a panel of medical experts in each case where a drug abuser is brought to trial on a charge of illegal possession and where, in the court's opinion, medical treatment may be indicated. The panel would make a determination as to whether the defendant has a medical problem associated with his abuse of drugs —a physical or psychological disability or drug dependence.

"If medical treatment is indicated, the panel would recommend to the court the type of treatment needed —that is, general—medical or psychiatric care; inpatient hospitalization or clinical treatment; group therapy; half-way house etc. If medical treatment is not indicated, or if measures in addition to medical treatment are needed, the court would then consider the non-medical handling of the case."

Under the proposed AMA changes, the HEW Department, rather than the Justice Department, would control the official classification of drugs, and the research and public education programs in the field. Control provisions would focus on manufacturers and distributors, rather than on physicians.

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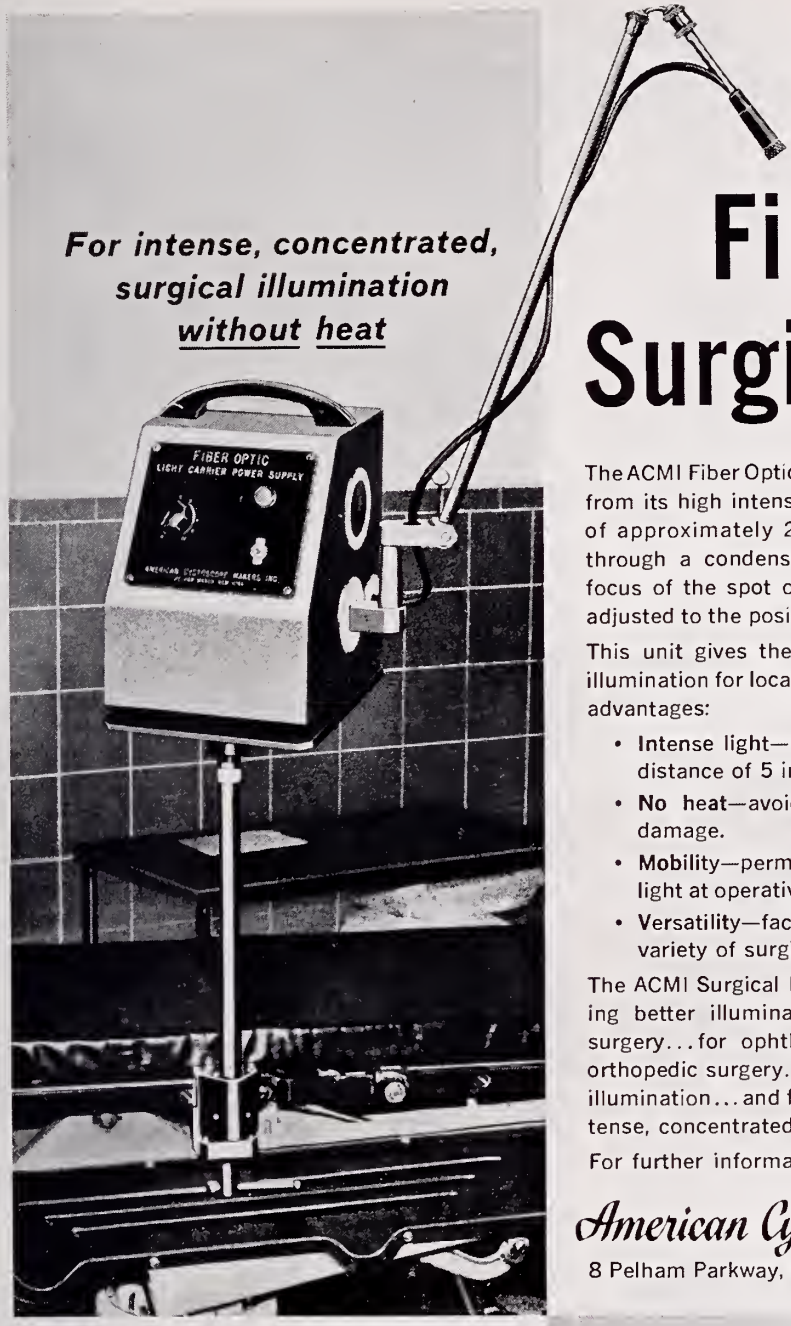

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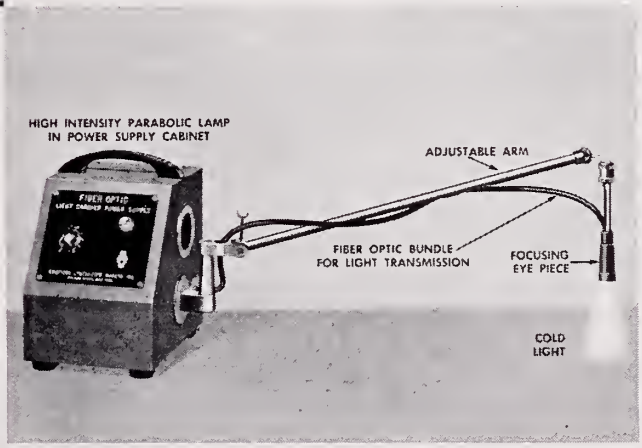

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Obituaries

HENRY HURT HANCOCK, M.D.

Dr. Henry H. Hancock died on October 6 at his home in Union, Monroe County, where he had practiced medicine for 30 years.

Doctor Hancock was born in Ruffin, North Carolina, and received his M.D. degree from the University of Virginia School of Medicine in 1937. He was 63.

During World War II, he served as a Major in the Medical Corps of the United States Army. He was a member of the American Academy of General Practice and was a former member of the West Virginia State Medical Association.

Survivors include the widow, Mrs. Hortense Herring Hancock; sons, Henry H. Hancock, Jr., of Morgantown, Lt. William H. Hancock with the U.S. Air Force in Korea; daughters, Mrs. Marion H. Shiflet and Mrs. Michael C. Smith, both of Union; brothers, Phillip B. Hancock of Warwick, Virginia, Chester I. Hancock of Mineral, Virginia, Ellett and James Hancock, both of Richmond, Virginia, and John Hancock of Greensboro, North Carolina; and sisters, Mrs. James Chesson of Tampa, Florida, and Mrs. George Hinkle of Rockville, Maryland.

* * * *

JOHN PATRICK HEAGARTY, M.D.

Dr. John Patrick Heagarty of Beckley died on September 24 at the age of 62.

A native of Savannah, Georgia, Doctor Heagarty atended the University of Georgia and received his M.D. degree in 1941 from the Medical College of Georgia. He interned at Wheeling Hospital.

During World War II, he served as a First Lieutenant in the Medical Corps of the United States Army.

He was a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Margaret Heagarty; a son, John Patrick, Jr., of Parkersburg; and daughters, Dr. Margaret Heagarty of New York City, New York, and Mrs. Mary Alice Burgan of Bloomington, Indiana.

* * * *

GRADY VEER MORGAN, M. D.

Dr. G. V. Morgan, 75-year-old retired Fairmont obstetrician, died in a South Miami, Florida, Hospital on September 17 after an illness of several weeks. He had resided in Coral Gables, Florida, for the past several years.

Doctor Morgan received his medical degree from the Cincinnati Eclectic School of Medicine in 1918 and began his practice in Fairmont that same year. While in Fairmont, he served terms as Chief of Staff of Fairmont General Hospital, and during World War II, he was a medical examiner for the Marion County Selective Service Board.

He was a former member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; three sons, Grady T. Morgan of Mamaroneck, New York, William R. Morgan of Elkhorn, Wisconsin, and John E. Morgan of Bryan's Road, Maryland; and a sister, Mrs. C. E. Amos of Fairmont.

* * * *

LYLE ALFRED MOSER, M.D.

Dr. Lyle A. Moser of the Putnam County community of Eleanor died on September 25 in a Charleston Hospital. He was 70.

A native of Pennsylvania, Doctor Moser attended Keystone Teachers College in Pennsylvania and received a B.S. degree from Lebanon Valley College before receiving his M.D. degree at Duke University in 1939.

He served internships at the University of Pittsburgh and at Wheeling Hospital.

Doctor Moser practiced medicine at Minden in Fayette County before moving to Charleston, then to Eleanor in 1949.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Ellen; a daughter, Mrs. Suzette Harris of Columbia, South Carolina; a son, Thomas, of Durham, North Carolina; a stepson, Commander R. R. Bottimore, Jr., of Sandusky, Ohio; brothers, Dr. G. P. Moser, A. Clair Moser and Glen Moser, all of Pennsylvania; and sisters, Mrs. Paul Henry of Allentown, Pennsylvania, and Mrs. John Parker of Wyoming, Delaware.

* * * *

SHIRLEY M. PRUNTY, M. D.

Dr. S. M. Prunty of Parkersburg died at his home on September 16 at the age of 88.

A native of the Ritchie County community of Berea, Doctor Prunty attended Fairmont College and received his M.D. degree from the University of Louisville School of Medicine in 1908. He did postgraduate work in New York City.

Doctor Prunty was an honorary member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mary Frances Costello Prunty; two sons, Dr. Francis C. Prunty of Parkersburg and James A. Prunty of New Orleans, Louisiana; two daughters, Mrs. Robert Hayes of Oakland, California, and Mrs. Elizabeth Day of Detroit, Michigan; eight grandchildren and seven great grandchildren.

* * * *

GEORGE DENNIS VAUGHAN, M.D.

Dr. George D. Vaughan, a former West Virginia physician, died in September in Richmond, Virginia, where he had made his home for many years. He was 57.

Doctort Vaughan spent his early life in Huntington, attended Marshall University, and received his M.D.

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degree from the Medical College of Virginia in 1939. In the early 1940s, he was engaged in medical practice in Logan County at Holden and was a member of the West Virginia State Medical Association at that time.

He was a member of the faculty of the Medical College of Virginia and was a Diplomate of the American Board of Colon and Rectal Surgery. His other professional memberships included the American College of Surgeons, the American Proctologic Society, the Southeastern Surgical Congress and the American Medical Association.

Survivors include the widow, Mrs. Doris Roper Vaughan; three sons, George Dennis Vaughan, II, Wilfred Allen Roper and Stephen C. Vaughan, all of Richmond; two sisters, Mrs. O. T. Clarke of Urbanna, Virginia, and Mrs. J. A. Ulmer of Chagrin Falls, Ohio, and a granddaughter.

Postgraduate Course in Pediatrics

A Postgraduate Course in Pediatrics will be held in Chicago, November 17-21 under the sponsorship of the Chicago Medical Society.

Discussion topics will include genetics and cell biology; child development and nutrition; school and social problems of children; immunology and allergy; perinatology; infectious diseases; and pediatric surgery.

A registration fee of $150 will be charged.

Information is available from: Chicago Medical Society, 310 South Michigan Avenue, Chicago, Illinois 60604.

County Societies

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held on September 10 at Doctors Memorial Hospital in Welch, with Dr. J. H. Murry, the President, presiding.

A Mrs. Taten of the Council of the Southern Mountains was guest speaker. She presented an interesting program on the Head Start Program in McDowell County.

Doctor Mury reported on the Heart Screening Program of the children in the County as set up by the Southern West Virginia Regional Health Council. The Society agreed to furnish $569.74 as matching funds to the Regional Health Center.—J. C. Ray, M.D., Secretary.

* * * *

MERCER

The regular monthly meeting of the Mercer County Medical Society was held in Bluefield on September 15.

Dr. N. Allen Dyer presented a status report on the Southern West Virginia Regional Health Council. He discussed many facets of the program, including family planning clinics, laboratory service, heart screening, solid waste program, tuberculosis control program and others.

Dr. William Bruch was named chairman of a committee to meet with Doctor Dyer to improve communications between the medical society and the

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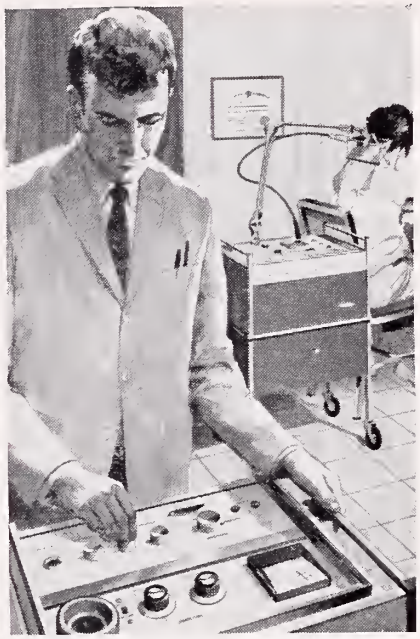

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Southern West Virginia Regional Health Council.—John J. Mahood, M.D., Secretary.

* * * *

MONONGALIA

Dr. N. LeRoy Lapp of Morgantown presented the scientific program for the regular monthly meeting of the Monongalia County Medical Society, which was held in Morgantown on September 2.

Doctor Lapp, Assistant Professor of Medicine at the West Virginia University Medical Center, spoke on "Coal Workers and Pneumoconiosis."

The Society voted to admit to membership Drs. Vicente Anido, Kamal M. Behnam and Richard V. Lynch, Jr., all members of the faculty of the WVU Medical Center. Doctor Lynch is a transfer from the Harrison County Medical Society.

Thirty-seven members and two guests attended the meeting.—W. Gene Klingberg, M.D., Secretary.

* * * *

RALEIGH

The regular monthly meeting of the Raleigh County Medical Society was held at Henry's Restaurant in Beckley on September 18, with 54 members and guests in attendance.

Guest speaker was Dr. James Kitchen of the Department of Obstetrics and Gynecology at the University of Virginia school of Medicine. Using the slide and lecture method, Doctor Kitchen described his experiences during his voluntary two-month tour of service aboard the hospital ship *S. S. Hope*.—John M. Daniel, M.D., Secretary.

Woman's Auxiliary

to the

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President Elect: Mrs. Robert J. Tchou, Williamson
Vice President: Mrs. M. Bruce Martin, Huntington
Eastern Regional Director: Mrs. Herbert Stelling, Romney
Northern Regional Director: Mrs. Myer Bogarad, Weirton
Western Regional Director: Mrs. Harold Van Hoose, Man
Southern Regional Director: Mrs. Robert G. Shirey, Lewisburg
Treasurer: Mrs. William T. Lawson, Fairmont
Recording Secretary: Mrs. Harvey Martin, White Sulphur Springs
Corresponding Secretary: Mrs. B. F. Puckett, Oak Hill
Parliamentarian: Mrs. A. J. Villani, Welch

(The following report was submitted by Mrs. Joe N. Jarrett of Oak Hill, President of the Woman's Auxiliary to The West Virginia State Medical Association, for publication in *The Journal*).

One of the purposes of the Woman's Auxiliary is to create and maintain good relationships between the families of physicians. This promotion of harmony should extend to medical students and interns and their families as well.

The Woman's Auxiliary to the West Virginia State Medical Association has a liaison between our group and the Woman's Auxiliary to the West Virginia Chapter of the Student American Medical Association (WASAMA), and our area of activities will be widened to include the local auxiliaries as well.

The West Virginia State Medical Association exerts similar efforts on behalf of the SAMA Chapter, and

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the general practitioners also are interested in establishing good relations between the medical students among us and the West Virginia Chapter, AAGP.

Concrete evidence of this interest in establishing lines of communication and increasing the holding power of our State for young doctors and their families was seen at a marvelous party held at the Holiday Inn in Morgantown the night before the West Virginia University-University of Maryland football game on September 20. A meeting of the Board of the general practice group was scheduled at the WVU Medical Center the next morning and the general practitioners with their wives turned out for a gay time on Friday night with the sophomore, junior and senior medical students and their wives or dates who had expressed a possible interest in the field of family medicine.

Attendance was excellent as were the refreshments. There was quite a generation gap, most of the students and their wives looking like our children or even grandchildren. They were a handsome bunch, mod in looks and attitude and brilliant and articulate in conversation.

There may have been a beard or two—I don't really remember—but I do know they were all clean cut, fresh and bright. The wives and dates were charming and what impressed us was the fact that the wives play such a large role in the choice of locale for setting up practice. It also impressed us how well they "manage" on small incomes. We talked with a number of working wives—some with children—and got the impression that with them medicine is a joint endeavor, as it surely should be.

Among the guests were Dr. Maynard P. Pride, President of the State Medical Association, and Mrs. Pride; Dr. C. Carl Tully, President of the West Virginia Chapter, AAGP, and Mrs. Tully; Mrs. Charles E. Andrews, our State Auxiliary Liaison to WASAMA, and Doctor Andrews. WASAMA Region Three Vice President, Stella Herrick, was there with her husband, Richard, as was WVU WASAMA's President, Kerr Crosby, with her husband, Tom. Richard and Tom are seniors in the School of Medicine.

Dr. and Mrs. Robert J. Fleming were in charge of arrangements and responsible for everyone having such a good time. By the time the party was over those still there gathered around the piano to sing to the accompaniment of a highly talented medical student. The generation gap evaporated as voices were joined in old and not-so-old favorites. Too bad such delightful "happenings" are so few and far between.

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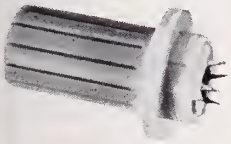

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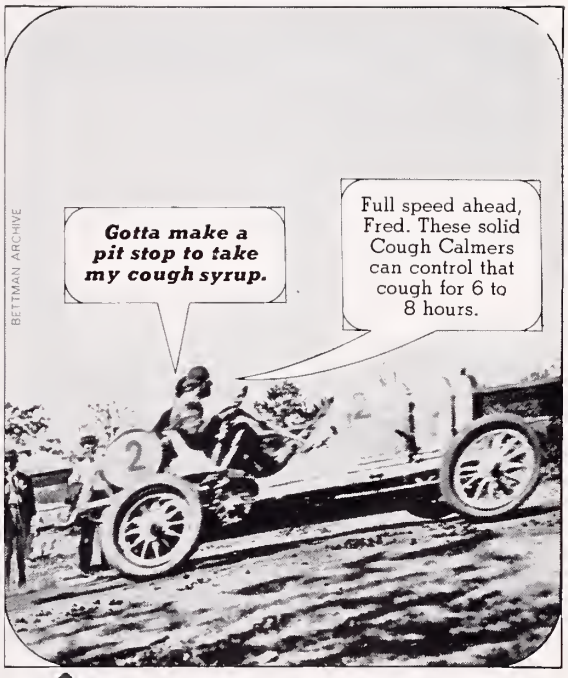

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DECEMBER
1969

Vol. 65 No. 12

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Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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WVU Medical Center
—News—

DR. Clark K. Sleeth, Dean of the School of Medicine for the past eight years, plans to retire from that position next June 30. He will continue on the faculty as Professor of Medicine.

Edmund B. Flink, M. D.

Clark K. Sleeth, M. D.

WVU President James G. Harlow appointed a 10-member committee to search for a successor. The committee is headed by Dr. Edmund B. Flink, Professor and Chairman of the Department of Medicine.

Other members of the search committee are: Dr. W. W. Fleming, Professor and Chairman of the Department of Pharmacology; Dr. Gunter N. Franz, Assistant Professor of Physiology; Dr. Lorita D. Jenab, Dean of the School of Nursing; and Dr. Barbara Jones, Professor of Pediatrics.

Dr. Donald L. Kimmel, Professor and Chairman of the Department of Anatomy; Mr. H. Gordon Minns, Jr., of Spencer, a second-year medical student; Mr. Eugene L. Staples, Director of University Hospital; Dr. Herbert E. Warden, Professor of Surgery; and Mr. Deleno Webb III of St. Marys, a third-year medical student.

Commenting on Doctor Sleeth's announcement Dr. Charles E. Andrews, Provost of Health Sciences, remarked: "Dean Sleeth has served with distinction as Dean of the School of Medicine during a period of significant growth. His leadership will be missed."

Doctor Sleeth, a native of Marion County, attended WVU and received his M. D. degree from the University of Chicago. He succeeded Dr. E. J. Van Liere as Dean in 1961.

Doctor Sleeth served an internship and a residency in medicine at Henry Ford Hospital in Detroit, 1939-41.

For many years he has been active in organized medicine. He is a former Secretary and President of the Monongalia County Medical Society, and in 1952, he was First Vice President of the West Virginia State Medical Association.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

New Preventive Medicine Chairman

Dr. James G. Harlow, President of WVU, has announced the appointment of Dr. Robert Lincoln Nolan, a physician and attorney, as Chairman of the Division of Public Health and Preventive Medicine.

Doctor Nolan will be Professor of Medicine and Pediatrics. He succeeds Dr. Ernest Chick, who resigned to join the University of Kentucky College of Medicine.

Doctor Nolan is one of the very few persons in the country who have earned doctorate degrees in both medicine and law. He completed his undergraduate studies at New York University and received his M. D. degree from Yale University.

After serving his internship and a residency and fellowship in pediatrics, Doctor Nolan became a pediatrician for the Health Insurance Plan Medical Groups of Greater New York. From 1958 until last September, he was Assistant Chief of Pediatrics and later Senior Partner of the Permanente Medical Group, Kaiser Foundation Hospital in Oakland, California. While there, he earned a master's degree in public health and a doctor of jurisprudence degree at the University of California at Berkeley.

Robert L. Nolan, M. D.

For four years prior to his appointment at WVU, he also was clinical instructor in pediatrics at Stanford University and the University of California. His special interests include studies of social class and medical care; legal medicine; and medical care administration, planning and legislation.

He is a diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, the American Public Health Association and the American College of Legal Medicine, and is a member of the American Bar Association.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

An American Medical Association spokesman outlined the AMA's voluntary national health insurance plan, "Medicredit," for consideration by the House Ways and Means Committee.

Dr. Russell B. Roth, Speaker of the AMA's House of Delegates and a practicing physician in Erie, Pennsylvania, said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans—no matter how limited their financial resources—of adequate health care protection.

"Representing this country's physicians as we do," Doctor Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

He estimated the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the Medicaid program. Medicare would continue.

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Doctor Roth said. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs. . . .

"Our proposal is the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the federal government's ability to fund a universal health insurance program. . . .

"It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30 per cent income range would, without cost to them, rceeive a certificate enabling them to purchase health coverage from qualified groups or plans."

The AMA plan calls for establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines. It would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members. It would review the effectiveness of the program and file annual reports with the President and the Congress.

Basic medical benefits of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credits.

Doctor Roth stressed the importance of utilizing private insurance carriers, thus taking maximum advantage of private sector competition to help hold costs down.

Another Plan Submitted

Rep. Durward G. Hall, M. D. (R., Mo.), a former member of the AMA House of Delegates, submitted to the committee another national health insurance plan. The first part of his two-part plan calls for the federal government to furnish persons eligible for Medicaid with health insurance certificates covering certain specified basic health protection. The states would have the responsibility for the balance of health care for an eligible individual after his basic coverage had been exhausted. Thus, the Hall plan would replace Medicaid.

The second part of the Hall proposal calls for the federal government helping, in cases of catastrophic illness, those persons who can afford normal health care insurance only.

Other national health insurance plans are being sponsored by Walter Reuther, head of the Automobile Workers' Union; the AFL-CIO; Sen. Jacob K. Javits (R., N. Y.), and Gov. Nelson Rockefeller of New York. Indications are that the committee will not give serious consideration to such legislation before next year at the earliest. It appears probable, however, that the issue will come to a vote in Congress before the 1972 elections.

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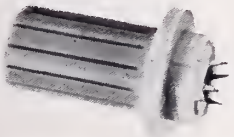

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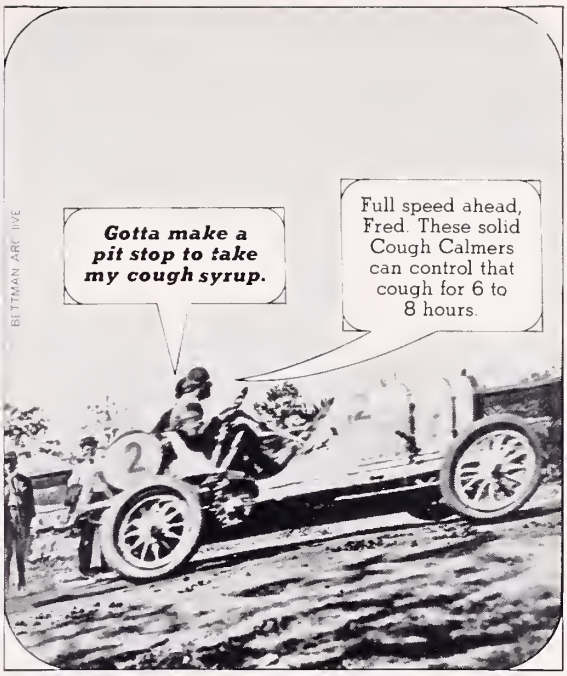

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Obituaries

WILLIAM POLLOCK BLACK, M. D.

Dr. William P. Black of Charleston died in a hospital in that city on October 22 after a brief illness. He was 84.

Born at Rupert, Doctor Black had resided in Charleston since 1917. He received his M. D. degree in 1914 from the University of Maryland School of Medicine.

Doctor Black was a Fellow of the American College of Surgeons and of the American Proctological Society. He was a Past President of the Kanawha Medical Society and also was an honorary member of the West Virginia State Medical Association and the American Medical Association.

He was one of the founders of Mountain State Hospital in Charleston and had served as Kanawha County Coroner and President of the Kanawha County Board of Health.

Doctor Black's survivors include the widow, Mrs. Grace R. Black; a son, William P. Black, Jr., of Charleston; a daughter, Mrs. James E. McClung of Richwood; sisters, Miss Sanna Black and Mrs. Harry Lawson, both of Columbus, Ohio, and Miss Mary Black of Morgantown; and a brother, Hollister A. Black of Roxboro, North Carolina.

* * * *

CARLOS HORATIO BOETSCH, M. D.

Dr. Carlos H. Boetsch, 35, of Charleston, was killed on October 23 when his automobile and a truck collided on the West Virginia Turnpike north of Beckley.

Doctor Boetsch, a thoracic surgeon, had moved to Charleston only last summer as associate to Dr. James H. Walker. He was a native of Argentina and received his M.D. degree in 1959 from the National University of Cordoba in Argentina.

He served his internship at Washington Hospital Center in Washington, D. C., and a residency in general surgery at St. Luke's Hospital in Milwaukee and at Charleston Memorial Hospital, 1962-66. He also served a residency in thoracic surgery at the University of Maryland, 1966-68.

Doctor Boetsch had been admitted to membership in the Kanawha Medical Society only a short time before his death. He is survived by his widow, Mrs. Sondra Lyon Boetsch; three sons, David, Charles and John, all at home; and the parents, Mr. and Mrs. Carlos Boetsch of Argentina.

* * * *

IGNATZ MARION KIZINSKI, M. D.

Dr. I. M. Kizinski of Weirton died in a hospital in that city on October 13 at the age of 72.

A native of Poland, Doctor Kizinski received a B.S. degree from West Virginia University in 1923 and his M.D. degree from Loyola University School of Medicine in Chicago two years later.

He was a former member of the Hancock County Medical Society, the West Virginia State Medical Association and the American Medical Association. During World War II, he served as a Captain in the Medical Corps of the United States Army.

Survivors include the widow, Mrs. Cecilia Kizinski; a son, R. Michael Olds of Hobbs, New Mexico; a daughter, Mrs. John Barbara of Weirton; a brother, John Kizinski of Parkersburg; a sister, Mrs. Patrick Gainer of Morgantown; four grandchildren and one great grandchild.

* * * *

WELLINGTON HENRY PARKER, M. D.

Dr. W. H. Parker, 95, died in Florida on September 30 after a long illness.

A native of Asbury, Doctor Parker had practiced medicine in Lewisburg and Ronceverte and at Amherstdale for many years before retiring to Florida several years ago. He received his M.D. degree in 1908 from the University of Louisville School of Medicine.

Doctor Parker was an honorary member of the Logan County Medical Society, the West Virginia Medical Association and the American Medical Association. He had served as President and Secretary of the Logan County Medical Society.

He also was a member of the Southern Medical Association and the Association of American Physicians and Surgeons.

Survivors include the widow, Mrs. Ella M. Parker; three daughters, Mrs. Lee Mitchel of Denver, Colorado, Mrs. Alberta Bailey of Louisville, Colorado, and Mrs. Jean Ramey of Charleston; and one son, Roy K. Parker of Charleston.

* * * *

WILLIAM FRANCIS POMPUTIUS, M. D.

Dr. William F. Pomputius of Beckley died in a hospital in that city on October 22 after a year's illness. He was 64.

Born at Nanty Glo, Pennsylvania, Doctor Pomputius completed his pre-medical studies at the University of Pittsburgh and received his M.D. degree from the School of Medicine there in 1930. He interned in Johnstown, Pennsylvania.

He became associated with Eastern Gas and Fuel Associates in 1930 and served as a physician at the communities of Kimberly, Montgomery, Powellton and Helen.

Doctor Pomputius was a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Mary M. Pomputius; three sons, Dr. William F. Pomputius, Jr. of Pittsburgh, Dr. James M. Pomputius of Springfield, Ohio, and Charles, at home; a daughter, Irene, at home; two brothers, Anthony of Teaneck, New Jersey, and Peter of Nanty Glo; a sister, Mrs. Stanley Walker, of Erie, Pennsylvania; and three grandchildren.

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OBITUARIES—(Continued)

WAYMAN J. THOMPSON, JR., M. D.

Dr. Wayman J. Thompson, Jr., 34, was found dead on October 31 at his home in Charleston.

A native of Oklahoma City, Doctor Thompson received a B. S. degree from the University of Oklahoma and was awarded the M. D. degree at the School of Medicine there in 1960. He interned in Oakland, California, and served residencies at the University of Oklahoma Medical Center, 1963-64, and at the Mayo Graduate School of Medicine, 1964-68. His specialty was pathology and he was Assistant Pathologist at Charleston Memorial Hospital.

Doctor Thompson was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Ann Rivers Payne Thompson; a daughter, Susan; the parents, Dr. and Mrs. Wayman Thompson, Sr., of Oklahoma City; and a sister, Mrs. Mary Denman of Oklahoma City.

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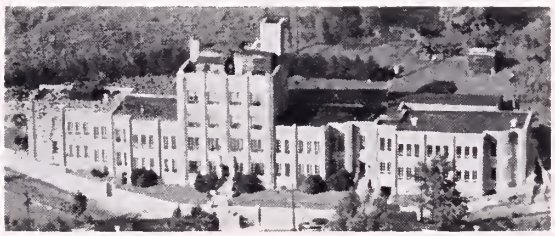

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County Societies

HARRISON

Dr. Philip Lerner of Cleveland was guest speaker at the regular monthly meeting of the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg on October 3.

Doctor Lerner, Professor of Infectious Diseases at Case Western Reserve Medical School, gave a paper on the use of antibiotics in modern medicine.

Members of the Harrison County Dental Society were guests of the physicians at the meeting.

* * * *

KANAWHA

The regular monthly meeting of the Kanawha Medical Society was held at the Daniel Boone Hotel in Charleston on Tuesday, November 11.

Guest speaker was Dr. John B. Harley, Associate Professor of Medicine and Director of the Division of Hematology at the West Virginia University Medical Center. Doctor Harley gave an interesting talk on "Current Concepts of Management of Hodgkins Disease."

* * * *

MARION

Dr. Maynard P. Pride of Morgantown, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Marion County Medical Society, which was held at the Union Mission in Fairmont on October 28.

The President discussed some of the projects and problems of the State Medical Association.

Dr. Robert G. Janes, President of the Society, conducted the business meeting, and Superintendent Joe Perry conducted a tour of the Mission's new addition.

* * * *

McDOWELL

The McDowell County Medical Society and its Woman's Auxiliary held a joint meeting in Welch on October 8.

Dr. J. H. Murry gave a report on the Heart Screening Program of children in the county, which is under the direction of Dr. Thomas E. Richardson. Dr. C. D. Pruett of Bluefield entertained the members with a medley of musical selections.—J. C. Ray, M. D., Secretary.

* * * *

MERCER

The Mercer County Medical Society and the Mercer County Bar Association held a joint meeting at the West Virginian Hotel in Bluefield on October 20.

Guest speaker was U. S. District Court Judge John A. Field, Jr., of Charleston. Judge Field discussed the U. S. Supreme Court and its influence on our lives.

Dr. Thomas Richardson was elected to membership in the Medical Society as a new member. Drs. J. Brennan Purkall, Jr., and George Chen King were elected to membership as transfers from the Richmond

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Academy of Medicine in Virginia.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Ludwig Gutmann, Acting Chairman of the Department of Neurology at the West Virginia University Medical Center, presented the scientific program for the regular monthly meeting of the Monongalia County Medical Society, which was held on October 7 with 31 members present.

Doctor Gutmann discussed L-Dopa therapy for Parkinson's Disease and said some very dramatic results have been obtained.

The Society admitted to membership Doctors Gutmann, Alptekin Ucmakli, Robert J. Marshall and Mabel M. Stevenson.

The Society voted to include the voluntary AMPAC-WESPAC contribution on the 1970 dues statement.—W. Gene Klingberg, M. D., Secretary.

* * * *

TYGART'S VALLEY

The regular monthly meeting of the Tygart's Valley Medical Society was held on October 16 at Blackwater Lodge with 40 members and guests in attendance.

Dr. H. Michael Dean, Fellow in Cardiology at the West Virginia University Medical Center, presented the scientific program. He gave an interesting paper on management of cardiac arrhythmias.

The Society admitted to membership Drs. B. H. Goerlich and Gerald T. Machinski.—A. Kyle Bush, M. D., Secretary.

Woman's Auxiliary

to the

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A CHRISTMAS MESSAGE

"Honor the physician . . .
according to thy need of him
with the honors due him. . . .

"The skill of the physician
shall lift up his head;
and in the sight of great men
he shall be admired."

Apocrypha, Ecclesiasticus 38:1, 3

As we approach the Christmas season, let us pause and regain our sense of direction which tends to become blurred as we daily meet life's joys, challenges and opportunities as well as its sorrows, burdens and disappointments. Let us get our bearing and be guided through imperfect Life by that wondrous event which

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through the centuries has guided mankind to perfect Eternity.

As in child-like awe we ponder the miracle of Christmas, may we ever remember the infinite love which prompted it. May this gift of love so fill our lives that we will be instrumental in stilling the tempests of our turbulent time by our efforts to unite the human family of young and old, black and white, Jew and gentile, and poor and rich in the common cause of ending worldwide hatred and strife.

What better time and place for recommitment to serve humanity than at this glorious season and in this honored place—the medical community? As representatives of that ancient art and noble profession quoted above may we so capture the spirit of Christmas that our lives will be a mighty force for peace and good will in the world.—*Mrs. Joe N. Jarrett, President, Woman's Auxiliary to the West Virginia State Medical Association.*

* * * *

MERCER

The Woman's Auxiliary to the Mercer County Medical Society held a coffee at the home of Dr. and Mrs. James R. Shanklin in September.

Mrs. R. O. Rogers, Jr., President, welcomed members and presided at the business meeting. Various reports were presented.

Mrs. Rogers appointed Mrs. Grady McRae as Chairman of a new committee on children and youth.

Mesdames B. Gurkan, H. Escandon and P. R. Higginbotham were introduced as new members.

* * * *

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society conducted its annual Membership Tea on September 18 at the home of Dr. and Mrs. J. D. H. Wilson in Clarksburg.

Mrs. Joe N. Jarrett of Oak Hill, President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest of honor.

Mesdames Sobisca S. Hall and C. Fred Fisher presided at the tea table, and arrangements were under the direction of the Social Committee, which is headed by Mrs. James A. Thompson.

Mr. Jerry Steiner of Clarksburg, an interior decorator, presented the program for a meeting of the Harrison County Auxiliary, which was held at the Stonewall Jackson Hotel in Clarksburg with 51 persons in attendance.

Mr. Steiner spoke on "Antiques and Their Uses in the Home."

Dr. Frank O'Connell, Professor of Pharmacy at the West Virginia University Medical Center, was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society, which was held on November 6 at the Stonewall Jackson Hotel in Clarksburg.

He gave a timely and informative talk on "Drug Abuse."

Our Readers Speak

(Continued from Page 426)

shortened life. When the Personal Polluter smokes in a poorly ventilated space in the presence of others, he infringes upon the rights of others and becomes a serious contributor to air pollution.

(Facts from an Editorial "A Damaging Source of Air Pollution" by Philip H. Abelson, Editor of Science; published in "Science" 22 December 1967—Vol. 158—Number 3808).

Thomas W. Nale, M. D.
Huntington

* * * *

MEDICINE AS A CAREER

Last week I had an occasion to address a group of junior and senior high school students on "Career Days." The topic was "Medicine and Its Related Subjects as a Career." All of the physicians of West Virginia need to interest more young people in medicine as a career. We need to emphasize the need "For People Doctors." All of the related fields to medicine must also have emphasis in order to aid the physician in the care of his patient. After training we need to interest them in staying in West Virginia.

C. Carl Tully, M. D.
South Charleston

Editor's Note: *Doctor Tully is President of the West Virginia Chapter, American Academy of General Practice.*

Mrs. Lawrence B. Thrush, President of the Auxiliary, presided at a brief busniess session following the program. Thirty-five members and 34 guests attended the meeting.—Mrs. William N. Walker, Jr., Publicity Chairman.

* * * *

KANAWHA

The Woman's Auxiliary to the Kanawha Medical Society held a coffee at the home of Dr. and Mrs. Rank Dawson on October 14. Theme for the meeting was "Be An Angel."

Each year the members of the Kanawha Auxiliary donate money to a Special Projects Fund in lieu of sending greeting cards at holiday time. This year prior to the October meeting, each member was invited to "Be An Angel" by Mrs. O. M. Harper and Mrs. George Miyakawa, Special Projects Chairman. As members arrived for the meeting, each had an angel handmade by Mrs. Harper pinned on her.—Mrs. D. Brown Barber, Publicity Chairman.

The West Virginia Medical Journal

Vol. 65, No. 1 January, 1969

Fundamentals of Heart Protection Through Physical Activity*

Wilhelm Raab, M. D.

The Author

- **Wilhelm Raab, M. D., University of Vermont College of Medicine, Department of Medicine, Burlington, Vermont.**

For many decades, vigorous physical activity was considered a potential hazard for the healthy, not to speak of the diseased, heart. Today, however, it is well established on experimental, clinical and epidemiological grounds that regular exercise constitutes not only a prerequisite for optimal maintenance of cardiac health but, with certain precautions, is of great therapeutic and rehabilitative value in cardiac patients who formerly were doomed to an inactive existence of physical deterioration and psychic depression.

One of the most decisive elements in this revolutionary change of views was the revelation in the forties that the once dreaded radiologically enlarged "athlete's heart" is an asset rather than a liability. Except for its size, the large strong heart of the highly trained sportsman represents in various respects the opposite of the equally enlarged (hypertrophic or dilated) but chemically and structurally diseased weak heart of the hypertensive patient with coronary atherosclerosis.

A particularly conspicuous distinguishing feature is the slow rate of the trained heart. It demonstrates an important cardioprotective mechanism of training, the significance of which is further accentuated by a prolonged isometric tension period of the trained left ventricle, as observed by several investigators, including ourselves, in many hundreds of instances. Both phenomena are attributable to a reduced sympathetic adrenergic, and increased vagal cholinergic tone of the cardiac autonomic nervous system.

These manifestations of antiadrenergic preponderance in myocardial function imply a more economical utilization of available oxygen, since a rapid heart beat and accelerated build-up of isometric tension require an augmented consumption of oxygen for the same amount of external work performance. Furthermore, a vagal prolongation of the ventricular diastole facilitates a better blood and oxygen supply to the ventricular tissue, since during this period of the cardiac cycle the muscular compression of intramural coronary arterioles is being relaxed.

The metabolic and microcirculatory factors affecting oxygen consumption and availability by a favorable reduction of the sympathetic and augmentation of the vagal tone, both at rest and in response to various stressful situations, assume their greatest cardioprotective importance in the presence of coronary atherosclerosis. Any narrowing of the coronary arteries and any diminution of their normal compensatory dilatability impair an adequate increase of oxygen supply to the myocardial cells when the latters' oxygen consumption rises under the influence of the neurogenically liberated adrenergic catecholamines, epinephrine and norepinephrine. Thus, the vascularly handicapped areas of myocardial tissue are in danger of functionally and structrually detrimental hypoxia, whenever acute or chronic sympathetic adrenergic preponderance, the autonomic nervous main characteristic of the sedentary individual's so-called "loafer's heart," dominates myocardial metabolism.

*Presented before a symposium on "Heart Disease and Exercise," sponsored by the Lawrence Frankel Foundation in Charleston, June 8-9, 1968.

Submitted to the Publication Committee, June 10, 1968.

The acute process of physical exertion as such, (in contrast to the sustained vagotonic state of being trained) is inevitably accompanied by intensive stimulation of the cardiac sympathetic nerves and a corresponding marked increase of myocardial oxygen consumption.

It may seem paradoxical that these episodes of greatly accentuated adrenergic activity are, in general, far better tolerated, even by hearts with existing coronary atherosclerosis, than was believed in the past.

According to recent studies, the answer to that puzzling question apparently is to be found in the behavior of the myocardial electrolytes, notably potassium. This requires a more specific explanation:

We know that intracellular electrolyte balance (high potassium vs. low sodium) constitutes an essential prerequisite for normal myocardial contractility, stimulus conduction, and structure. Local hypoxia is always associated with loss of potassium from, and gain of sodium by the affected cells. Accordingly, vascularly damaged, hypoxic areas of the heart muscle display a low potassium and high sodium content, which is responsible for much of the common abnormal functional and structural features of the heart, including multiple focal necrotic destructions.

Administration of potassium, especially in association with insulin and glucose or with aspartic acid, which promotes the entry of potassium ions even into hypoxic heart muscle cells, has been found to correct functional cardiac disturbances (contractile weakness, arrhythmias), and to prevent development of necrotic lesions.

Doctor Raab's paper in this issue of *The Journal* is a summary of a presentation given during the symposium on "Heart Disease and Exercise," sponsored by the Lawrence Frankel Foundation in Charleston, West Virginia, June 8-9, 1968.

Other speakers at the meeting were Ernst Jokl, M. D., Professor and Director, Exercise Research Laboratories, University of Kentucky, Lexington; Hans Kraus, M. D., Associate Professor of Physical Medicine and Rehabilitation, New York University Medical School, New York; Maj. Kenneth H. Cooper, U.S.A.F., MC, Aero-Space Medical Laboratory, Lackland AFB, Texas; who reported on "Notation of Exercise—Description of Method, Exemplification of Its Application in Experimental Epidemiology—Study of the Influence of Sustained Physical Training Regime on Normo-and Hypertensive Middle-Aged and Old Men," "Hypokinetic Disease—Low Back Pain, Tension and Stress," and "Testing and Developing Cardiovascular Fitness Within the United States Air Force," respectively.

Due to limited space the papers other than that by Doctor Raab are being published elsewhere and reprints of all papers presented at the Symposium may be obtained by writing the Lawrence Frankel Foundation, Brooks at Virginia Streets, Charleston, West Virginia 25301.

During exercise, large amounts of potassium are extruded from the contracting skeletal muscles (and, possibly, from the liver) into the circulating blood. The resultant marked hyperkalemia persists only for a minute or two after termination of muscular effort, due to rapid reabsorption of the circulating potassium by the body tissues, including the heart muscle. In animals, the myocardial potassium content was found significantly increased for periods of 24 to 36 hours after vigorous exercising. During that period the heart muscle proved remarkably resistant to otherwise necrotizing agents and stresses.

Only in recent years was it discovered that patients with angina pectoris are frequently able to continue exercising through their attacks of pain until and beyond the latters' cessation, with following improvement of their subjective condition as well as of the electrocardiogram. This unanticipated phenomenon may be explained by the following sequence of events: (a) Effort with sympathetic stimulation, causing hypoxic extrusion of myocardial postassium and pain; (b) rise of serum potassium extruded from contracting skeletal muscles, and transfer of part of it into the myocardium when a high serum level has been reached; (c) cessation of distress and normalization of electrocardiogram.

In connection with pathogenic myocardial electrolyte problems it is of interest that potassium-depleting cardiotoxic catecholamine action is greatly aggravated by simultaneous overproduction of likewise potassium-depleting corticoids from the adrenal glands, e.g., under emotional stress or nicotine action. Fortunately, such a potentially cordiotoxic overactivity of the adrenal cortex does not occur during moderate, nonexhausting muscular exertion.

The cardiac hazards of unaccustomed and suddenly starting intense physical effort in the untrained, particularly in the elderly with coronary atherosclerosis or myocardial damage, seem to be inherent chiefly in a lack of autonomic nervous, hormonal, and hemodynamic preadjustment.

A partial safeguard against exercise-induced myocardial overstrain seems to be the fact that, contrasting with the rising systolic blood pressure, the diastolic pressure often declines during activity, thus faciliating an adequate coronary blood flow through the subendocardial layers of the left ventricle.

Although active sportsmen have usually a somewhat lower systolic blood pressure than otherwise comparable groups of sedentary individuals, physical training does not, in general, result in a major reduction of pathologically

elevated blood pressure levels, either systolic or diastolic, and cannot be regarded as an important antihypertensive factor.

Neither does there exist any convincing evidence of an antiatherogenic effectiveness of physical training. Frequently made statements to the extent that exercise prevents or retards the development of coronary atherosclerosis are based on the widespread semantic confusion of vascular morphological with myocardial metabolic pathology. While it is true that coronary atherosclerosis does indeed represent the most important and most common predisposing and contributing element in plusicausal degenerative, so-called "coronary" heart disease, the cardioprotective value of physical activity must be attributed primarily, if not entirely, to its widely underestimated or disregarded but nevertheless crucial myocardial metabolic effects.

The somewhat problematic and controversial interference of physical activity in lipid metabolism, i.e., lowering of serum cholesterol and triglycerides, may be regarded as a possible antiatherogenic mechanism, however, of probably only minor preventive significance.

Reduction of obesity, a recognized cardiac risk factor, is usually achieved by a combination of muscular and dietary efforts, which makes the specific evaluation of each of these factors difficult. Loss of excess body weight *per se* appears to contribute an important element in cardioprotection by decreasing the mechanical circulatory demands imposed upon cardiac ventricular work and oxygen consumption.

Probably the most important beneficial effect of physical training on the coronary vascular system concerns the growth and opening of new collaterals in areas of the heart muscle which are subjected to the vasodilatory stimulus of local oxygen deficiency. This circumstance seems to predestine that particular aspect of training more to the rehabilitation of predamaged, diseased hearts than to primary disease prevention in healthy individuals.

Whether or not certain observations concerning an augmentation of fibrinolytic activity of the blood by exercise and training have any bearing on the problem of cardioprotection remains an open question. This is the case, especially in view of the fact that thrombotic coronary occlusion, apart from being nonexistent in more than 50 per cent of fatal myocardial infarcts, is increasingly being interpreted as a local, chemically and hemodynamically induced sequel rather than as a primary cause of myocardial infarction.

No systematically organized, large scale application of the cardioprotective principles of regular vigorous physical activity has yet been initiated by the health authorities and medical profession of the disastrously heart disease-ridden Western nations. For decades, the contrast to the vast prophylactic action programs in the dynamically prevention-oriented Communist countries has been most striking. In the latter, less emphasis is being placed on indefinitely protracted, sophisticated research "until all the facts are known", than on determined mass-educational and practical action.

The Soviet-inspired rural reconditioning center system for the preventive training and health education of about five million potential heart disease candidates per year is highly developed in Eastern Europe, and has been expanded over the last fourteen years to West Germany, Switzerland, Austria and Sweden under the sponsorship of governments, industries, and insurance organizations. Nothing comparable exists in the U.S.A.

Some ambitious and effective urban training programs for precardiacs and cardiacs are being conducted in this country on a limited scale by academic institutions, Y.M.C.A.'s. and some private groups. However small, they represent an encouraging beginning of an urgently needed trend toward restoration of our badly deteriorated national physical fitness and cardiac health.

Summary

Present-day knowledge concerning the fundamental mechanisms involved in the protection of the human heart muscle against rampant degenerative, so-called "coronary" heart disease is based on our growing insight into the complex, vascular, neurogenic, hormonal, and myocardial metabolic pathogenesis of that pluricausal condition.

Beneficial preventive effects of muscular training are, in all likelihood, attributable chiefly to an improvement of the autonomic nervous regulation of myocardial metabolic oxygen economy and electrolyte balance. Exercise-induced opening of coronary collaterals seems to compensate for the detrimental effects of already established local hypoxia in the heart muscle.

There is little, if any, evidence available to suggest a retarding influence of physical activity on the development of coronary vascular atherosclerosis. The latter is frequently being indiscriminately confused with the clinical features of metabolic myocardial tissue pathology, especially in epidemiological statements.

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Strokes Caused by Extracranial Vascular Disease*

Thomas W. Langfitt, M. D.

UNTIL recent times the diagnosis of occlusion of the cervical portion of the internal carotid artery rarely was made except in the case of patients with ipsilateral monocular blindness and contralateral hemiplegia. Hunt[1] first described this syndrome in detail, and Moniz[2], the father of angiography, first demonstrated occlusion of the internal carotid artery with contrast material. Occasional cases continued to be diagnosed during the ensuing years, but emphasis centered on intracranial vascular occlusion. The impetus for a more thorough evaluation of extracranial vessels in patients with strokes was provided by the pathological studies of Fisher[3] who demonstrated occlusive disease in the cervical vessels in a significant number of cases in which the patients had died from cerebrovascular accident.

In the past decade many thousands of patients with clinical evidence of cerebrovascular insufficiency have been studied angiographically and treated by a variety of means. The incidence of extracranial occlusive disease is still difficult to define, because criteria have not been clearly established. In Crawford and De Bakey's[4] series of some 2,300 cases of cerebrovascular insufficiency, 50 per cent of patients had extracranial occlusive disease as the apparent cause of their stroke symptoms. Millikan[5] reported the status of extracranial vessels in 100 consecutive post mortem examinations of patients 50 years of age and more. There were 15 occlusions in 11 subjects. Six patients had never had symptoms suggestive of cerebrovascular insufficiency. Twenty-nine of the 100 patients had a total of 77 stenoses (50 per cent or more occlusion of the vessel), and 18 of the 29 patients were asymptomatic. Forty-five of the 77 stenotic lesions were at or near the bifurcation of the common carotid artery. Thus, atherosclerotic stenosis and occlusion of extracranial vessels are very common in the older age group, but many patients are spared the consequences of cerebral ischemia by development of adequate collateral circulation.

Heretofore most observers have assumed that the principal, if not the only deleterious effect of an arteriosclerotic plaque, is reduction in blood flow through the diseased vessel. The problem then is establishing the degree of stenosis required to produce a critical reduction in blood flow through the vessel. In recent years, however, emphasis has shifted from insufficiency to embolization, and there is now considerable evidence that transient neurological deficits in patients with internal carotid artery stenosis are due to intermittent showers of emboli from the plaque rather than cerebrovascular insufficiency from a transient fall in blood pressure or some other cause. Thus, a small plaque that has no direct effect on cerebrovascular dynamics may well be the source of emboli. Whereas surgery might not be indicated in a patient with a 25 per cent stenosis of the internal carotid artery on the basis of the stenosis alone, surgery would be warranted if embolization from the plaque creating the stenosis could be proven.

The Author

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Clinical Syndromes

Three syndromes of cerebrovascular insufficiency are generally recognized, and the categorization of each patient is important in determining whether the patient should be treated, the kind of treatment to be used, and how rapidly it should be effected. Interest has centered on patients with intermittent neurological signs and symptoms (transient ischemic attacks). The patients are neurologically normal when first seen and are therefore afforded the greatest potential benefit from therapy. Typically, the patient presents with a history of transient loss of function in one or both extremities on the same side. This may be in the form of weakness, or numbness and paresthesias, often combined with some disturbance of speech if the dominant hemisphere is affected. The attacks are recurrent, often several in a week, and last from a few minutes to several hours. Although the patient states that he has recovered completely, a careful neurological examination sometimes reveals slight residual changes.

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The second category is the progressing or evolving stroke. The patient presents with a history of days or weeks of a gradually developing unilateral motor or sensory deficit. Some evidence of undulation in the course can often be elicited, but the initial diagnosis in these patients usually is an expanding intracranial mass rather than cerebrovascular disease.

The third clinical syndrome is the fixed or completed stroke. The patient may have had transient ischemic attacks in the past, he may be in the end stage of a progressing stroke, or the neurological deficit may have come on quite suddenly. The hemiplegia is profound indicating marked involvement of cerebral function.

These descriptions apply to strokes in the distribution of the carotid circulation, and ordinarily vascular lesions in the cerebral hemispheres are considered to be far more common than elsewhere in the brain. Vertebrobasilar insufficiency also is quite common, however, and a high index of suspicion is required to identify the many syndromes caused by lesions in the posterior circulation. One of the most common symptoms is intermittent vertigo or dizziness with or without auditory symptoms. This may be difficult to distinguish from Meniere's disease or other labyrinthine disorders. Homonymous field defects or complete cortical blindness due to insufficiency in the posterior cerebral arteries also occur. The patient may have attacks of syncope, due to brain stem ischemia, that are difficult to distinguish from various forms of epilepsy. Finally, "drop attacks" also are caused by brain stem insufficiency. The patient falls suddenly to the ground, without loss of consciousness, then is able to get up without assistance and continue on his way until the next attack.

The subclavian steal syndrome has received considerable attention since it was first described by Reivich[6] et al. The patient may state that he loses consciousness whenever he vigorously exercises one of his arms. The lesion consists of occlusion or severe stenosis of the subclavian artery proximal to the origin of the vertebral artery. Blood ascends the normal vertebral artery, then refluxes down the opposite vertibral into the subclavian artery distal to the occlusion. The abnormality is exaggerated by exercise of the arm ipsilateral to the subclavian artery occlusion. Thus, during exercise the muscles' arterioles dilate, lowering peripheral resistance, and blood is "stolen" from the brain stem.

Physical Diagnosis

Stenosis of the internal carotid artery at its origin often can be diagnosed by examination of the neck vessels. Palpation is rarely helpful because some asymmetry in pulse amplitude often is present normally, and the internal carotid artery passes behind the external carotid immediately above its origin. The vessels are quite deep at this level, and the external carotid provides a pulse that is approximately equal to the two arteries combined. Also, a thrill is rarely palpable. Auscultation, on the other hand, often reveals a bruit, and since stenosis of the external carotid artery is uncommon, the bruit can usually be attributed to internal carotid stenosis. If the vessel is completely occluded, there is no bruit.

An absent common carotid pulse on the right indicates complete occlusion of the common carotid artery, most likely at its origin. If, in addition, pulses are absent in the right upper extremity, the occlusive disease is in the innominate artery. Absent pulses in the left upper extremity indicate subclavian artery occlusion, and in the subclavian steal syndrome pulses are diminished or absent. Stenoses in the major branches of the aorta often can be diagnosed by bruits heard over the base of the neck or at the thoracic outlet.

The most useful clinical test in the diagnosis of cervical carotid artery insufficiency is ophthalmodynamometry.[7] This is an indirect method for measuring retinal artery pressure and there is reasonably good evidence that pressure in the retinal artery provides an approximation of pressure in other branches of the internal carotid, such as the middle cerebral artery. The systolic and diastolic pressures are compared in the two eyes, and a 20 per cent difference is significant. The test is an exacting one requiring considerable experience.

Angiography

The purpose of angiography is to demonstrate a lesion in the cerebral circulation that can account for the patient's neurological picture. This is not an easy goal to achieve because of the complex anatomy and physiology of the collateral circulation. Thus, a dynamic approach to the study of the cerebral circulation is required, rather than concentrating on the most easily demonstrated and largest plaques in major vessels. Angiography in these patients should include visualization of the entire extracranial and intracranial circulation. Direct puncture of both common carotid arteries is still used most frequently in patients with strokes that appear to be confined to the carotid circulation. This procedure, however, does not visualize the posterior circulation nor the origin of the large vessels in the neck. Also, there is the risk of dislodging emboli from a plaque at the origin of the internal carotid. Retrograde brachial arteriography is

most frequently used to demonstrate the posterior circulation, and a bilateral study will demonstrate the entire circulation except for the left carotid. The procedure of choice, in my opinion, is selective catheterization of each major artery from the aortic arch. A radiopaque catheter is passed into the arch from the femoral artery and directed into each orifice under image intensification. This requires experience, but all angiography should be in experienced hands.

Treatment

The purpose of treatment of extracranial vascular disease is to improve blood flow through ischemic or potentially ischemic brain. This can be accomplished by surgical repair of large arteries that supply the involved region or by anticoagulation. The latter improves local flow dynamics by reduction of sludging, prevention of microthrombi, and perhaps other beneficial effects that are not fully understood.

The indications for surgical treatment are demonstration of significant stenosis or total occlusion in an accessible portion of a major extracranial artery and evidence that the occlusive disease is responsible for the patient's neurological syndrome. The latter may be difficult to prove in patients with multiple lesions because of the complexity of the collateral circulation that develops. Establishing the significance of degrees of stenosis also is a difficult problem because the physical factors governing the volume of blood that flows past an irregular stenotic region are complex. For example, during gradual occlusion of the carotid artery with a clamp it is necessary to obliterate 70-90 per cent of the lumen before a reduction in blood flow occurs.[8] If one believes that the stenotic region acts primarily as a source of emboli, then the degree of stenosis is a less important criterion for surgery.

Many technical advancements have been made in vascular surgery in recent years and have been applied to the problem of extracranial vascular disease. The choice of technique depends on the location of the lesion, whether the occlusion is partial or complete, and whether the patient will tolerate transient complete occlusion of the vessel during the repair. Complete occlusions of the large branches of the aorta often are confined to sufficiently small segments of the vessel to permit use of a by-pass graft. For example, the subclavian steal syndrome is treated by insertion of a graft from the arch of the aorta to the distal patent subclavian artery, thereby restoring normal pressure to the subclavian circulation and preventing retrograde flow of blood in the vertebral artery. The common carotid artery may be completely occluded throughout its length, but if the internal and external carotid arteries are patent, as usually is the case, a graft can be inserted from the aorta to the internal carotid. Complete occlusion of the internal carotid artery at its origin, the most common point of occlusion in the extracranial circulation, is almost always associated wtih propagation of the thrombus up the internal carotid artery and out of the operative field. By-pass grafts, therefore, are not feasible with ordinary techniques, and circulation can be restored only if the clot can be teased out of the vessel. Experience among surgeons has varied considerably, but there is approximately a 50 per cent chance of removing the thrombus if the patient is operated on within 24 hours of the total occlusion. Beyond that time the chances of success decrease rapidly. If, at the time of surgery, back bleeding from the internal carotid artery in the neck is not obtained, the distal clot has not been removed, and the operation has been a failure.

Arterial stenoses are treated by arteriotomy, endarterectomy, and restoration of the vascular lumen so as to reduce as much as possible the chances of recurrent occlusion. Often simple resuturing of the arteriotomy incision is all that is required, but when this results in reduction in the size of the lumen in the small end of the vessel, a patch graft at the site of the arteriotomy is required.

Shunts may be used to avoid ischemia during the several minutes required to do the endarterectomy. This can be accomplished with an internal shunt passing through the operative field or an external shunt that is looped around the vessel. Some surgeons prefer to operate under local anesthesia in order to monitor the patient's neurological status throughout the operation. Others use general anesthesia, often with inhalation of CO_2 and induced arterial hypertension in order to enhance cerebral blood flow. Repeat angiography is required following surgery to demonstrate whether or not the surgery has been successful, unless there is reason to believe that another angiogram carries higher than usual risks.

The results of surgical treatment of stenotic regions throughout the extracranial circulation and of complete occlusions near the arch of the aorta continue to be very encouraging. Crawford and De Bakey[4] reported on 536 patients with occlusive disease of the innominate, carotid, subclavian, and vertebral arteries. There was a total of 1,047 lesions, more than half of which were

in the internal carotid artery. Circulation was restored in 93 per cent of the arteries. The results in patients with completed stroke were poor, since by definition the patient must have sustained severe brain damage prior to surgery. Among those patients with transient ischemic attacks, however, 80 per cent were asymptomatic at the last follow-up. Similar results were reported by Murphy and MacCubbin.[9]

A second method of treatment that has been used extensively, with varying degrees of enthusiasm, is anticoagulation. A large series of cases with careful follow-up was reported by Millikan[10] et al and Siekert.[11] Only patients with transient ischemic attacks and progressing strokes were treated. Groups of treated and untreated patients were compared. In the treated group of patients with transient ischemic attacks 80 per cent were neurologically normal one to five years following the institution of therapy, and the attacks had disappeared. Only two per cent had gone on to cerebral infarction. The untreated patients did not fare so well. Twenty-four per cent continued to have attacks and 20 per cent developed cerebral infarctions. Perhaps the greatest deterrent to treatment of stroke patients with anticoagulants has been fear that the patient may have an intracerebral hemorrhage rather than thrombosis or that a pale infarct may be converted into a hemorrhagic infarct. In Siekert's series the incidence of cerebral hemorrhage was low, five per cent both in the treated and untreated groups.

The effects of anticoagulation therapy on thrombotic stroke reported by Baker[12] are not so encouraging. He compared 59 treated patients with a control group of 69 patients. During the treatment period the incidence of recurrent attacks and of cerebral infarction was only slightly less in the treated group compared with the control group. Long-term evaluation following discontinuation of therapy gave similar results. There was some increased mortality in the treated group due either to cerebral or gastrointestinal hemorrhage, but despite this the overall mortality rate in the treated group was better. Baker concluded, however, that the incidence of transient ischemic attacks was not significantly affected by the treatment.

Conclusions

The proper diagnosis of extracranial vascular disease and the establishment of its significance in terms of the patient's neurological status is dependent on a careful neurological examination plus physical evaluation of individual vessels using those often neglected tools, observation, palpation, and auscultation. All of the large extracranial vessels are then visualized by angiography.

Selection of patients for treatment and the type of treatment to be used are still difficult decisions, but the amount of information now available is sufficient to warrant establishment of certain guidelines. The patient with a severe, completed stroke is not a candidate either for surgery or anticoagulation because the damage already has been done, the mortality from surgery is high, and many of these patients have either a primary hemorrhage, rather than thrombosis, or a hemorrhagic infarction. Patients with progressing, incomplete strokes are candidates either for surgery or anticoagulation but, again, one must be certain of the nature of the cerebrovascular accident. Patients with transient ichemic attacks are the best candidates for treatment because they are neurologically normal and therefore provide the best salvage rate.

In my opinion, all extracranial stenotic vessels should be operated on if 50 per cent or more of the lumen is occluded, if the patient's neurological syndrome is compatible with insufficiency in that artery, if the intracranial circulation is adequate and, finally, if the patient's age and general condition do not contraindicate surgery. These "if's" beg several issues. Arteriosclerotic plaques compromising less than 50 per cent of the vessel lumen may be sources of emboli and, if so, they should be removed. Improvement in extracranial blood flow may benefit the patient even though he has a poor intracranial circulation. The development of collateral circulation may be adequate, and relief of the stenosis is therefore unnecessary. Other objections could be raised, but criteria for treatment must be established even though in the long run they may prove to be inadequate or incomplete. Anticoagulants, in my opinion, should be reserved for those patients who are not candidates for surgery. In so doing, one loads the statistics against anticoagulation, but I believe this method of treatment is not a substitute for surgical reconstruction of a severely diseased artery.

Since intensive study of the problem continues, one can hope that the many variables involved will become more manageable with better clinical information. Also, methods are not available for the clinical evaluation of cerebrovascular dynamics, particularly regional cerebral blood flow. These techniques, in combination with new developments in neuroradiology, may permit a more logical selection of patients and better evaluation of the results of treatment.

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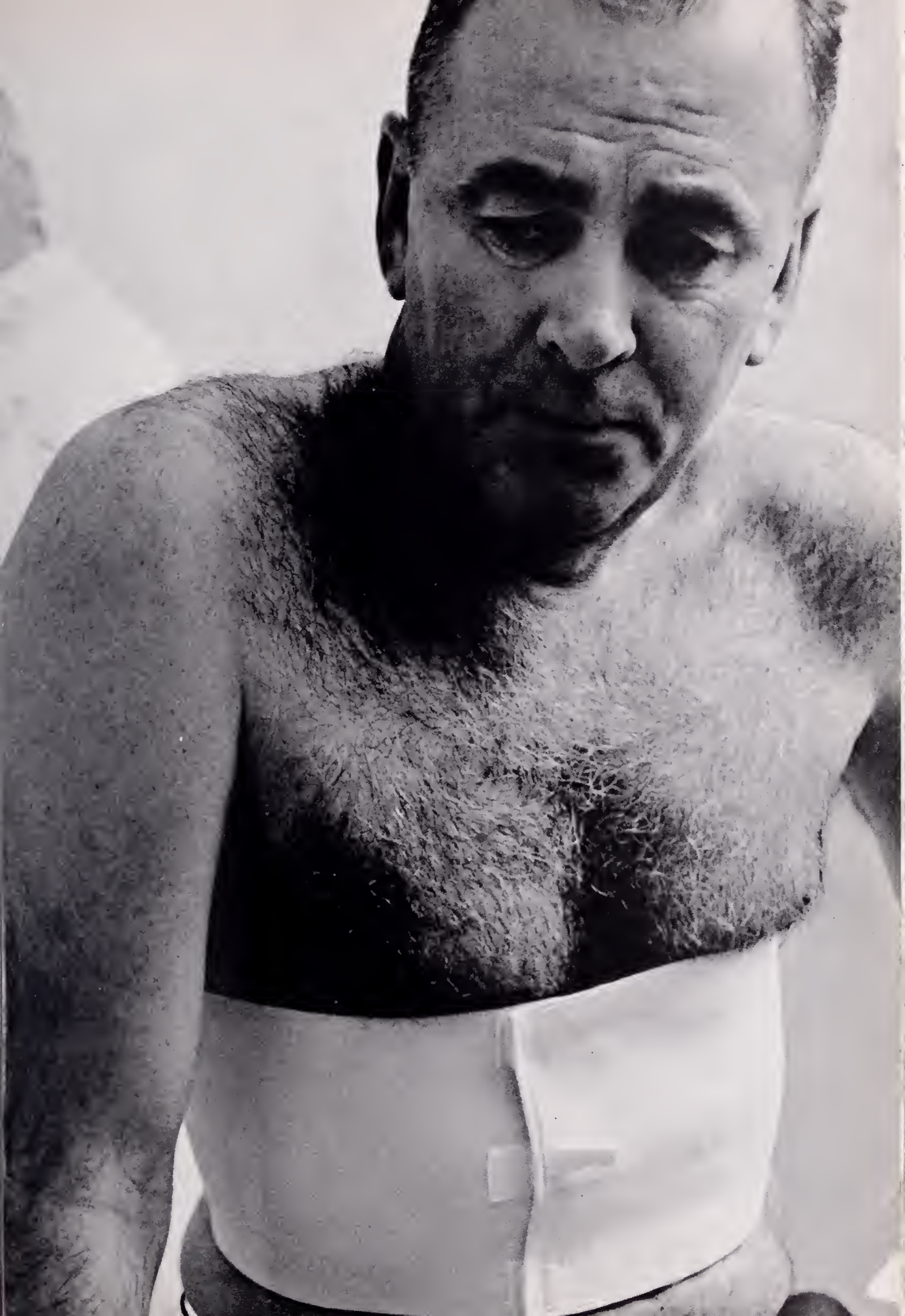

Sexual Problems in Clinical Practice*

Robert A. Ross, M. D.

An obstetrician and gynecologist can experience real satisfaction being on a scientific panel with a pediatrician and psychiatrist discussing "Sexual Problems in Clinical Practice" at a State Medical Association meeting. These are the three medical disciplines that have almost gratuitously offered advice and counsel to patients or groups concerning this important topic. If one could choose an additional speaker, a common sense marriage counselor might be added to the group. Furthermore, a speaker who is a member of a medical school faculty has added opportunities and responsibilities. He is confronted with the awesome body designated "curriculum committee" which allocates teaching hours. The medical schools, however, are undergoing revolutionary changes regarding curriculum, influenced greatly by the perspicacity and insight of mature students. Reproductive biology, family counseling, social behavior and mental health must be considered by all faculties in order to offer a more complete experience to an alert student body.

The obstetrician realizes that he probably has missed "grandma," but he is intimately concerned with mother and daughter from birth to premarital status and, equally important, son-in-law to be and son-in-law in fact. The female during climacterium, whether a physiologic process or a deficiency disease; the mother with an exacting brood or, sometimes equally perplexing, the "mother" without a child; the exigencies of family life; the new adjustment to married life; the anticipation and misinformation associated with the premarital phase; the unwed mother, the teenage pregnancy; the adolescent; the pubescent, and the newborn female all constitute a full source of actual or potential problems in the broad category of human sexuality. Added to this is the all too familiar female who presents herself to the doctor with the truthful statement that she does not know what is wrong but she is certain that something is wrong—the "nervous female." This latter female cannot be overly treated; she must have sympathetic audience. The danger, in our opinion, is that she be overly operated upon.

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Ideally, management of overt or evident sexual maladjustment should certainly be explored at the first visit to the physician's office. Judgment should tell how far and how much this topic should be pursued at this time. An insight is possible, and if manifest can be carried on with tact; the patient will know if the doctor has a genuine interest and the ability to be of help.

The patient in the office is not the entire obligation. Our profession should be concerned about parents, society, schools and trends. Counsel the adult couple; advise the premarital group; be sympathetic to the teenage, though it will be difficult to know if the sympathy is reciprocal or even noticed; be available for church, civic, social and school classes including all grades; and, most important, look into the home where actually the primordial responsibility lies.

The meeting of the obstetrican, the new patient and "sex" occurs at the birth of a baby. It is necessary to label the infant "male" or "female." This is sex, what you are, not the usual connotation, what you do. The problem of human sexuality can appear this early in the unfortunate indeterminate or ambiguous infant with anatomic, genetic or chromosomal defects. These relatively rare complications usually can be managed with some satisfaction and understanding. More often than not, a satisfactory sexual life, if not reproductive life, can be assured.

Teenage sexuality, promiscuity, and teenage unwed pregnancy offer a paradox of change and consistency: a change in surroundings and socioeconomic influences, and a consistency in that each generation feels that it has found something new in boy-girl relationship.

Sex education is difficult to define and difficult to evaluate. TV advertisements, automobiles, cosmetics and even appliances can misinterpret sex. Misinformation also comes from peer groups, a group usually highly respected by the teenage. An inaccurate vocabulary, slang, vulgar terms,

filth, misnomers and odd terms for human sexuality lead to disrespect for the human body and for morality; promiscuity can result.

When school responsibility and opportunity arrive is debatable. At the two poles are the early approach with progressive depth as the child advances from kindergarten to high school, and the austere reaction noted in some of our own communities where the P.T.A. requested one of our most temperate and knowledgeable members to please not give another talk to the students. The "buck passing" technique—from science teachers to biology to psychology, to English teacher to athletic coach—is often encountered. The sex scare-sex fear is most often hinted at and can produce chiefly a negative attitude. The same is true of the crisis: X number of girl students are pregnant and rapid treatment is in order, and worthless.

Some "family life" type programs that deal with adultery, alcoholism, divorce, drug addiction and venereal disease lead to disgust and repugnancy. As one high school student said, "If that is family life, I want no part of it."

The question is asked, "Where can we find people trained for this delicate job?" The answer is simple: In your own backyard. If intelligent, interested people gather and carry on sensible dialogue, in due course several such persons will stand out. After all, what one is teaching is good mental and physical health, good conscience and good taste. The vocabulary is not too important; forthrightness, judgment and being able to interpret the reaction of the group are important. With no apologies.

The physician is not entirely responsible for, nor is he the dictator of, love life in his community; neither is the editor of "Playboy." The physician can be a wise counselor. Nor has he suggested dispensing the "pills" like salt tablets nor absolutely forbidden their use. Many will and should take the time to explain to girls and boys why the "pill" is not the better part of wisdom, even when the young assume a proprietary attitude concerning sexual liberty and license. This attitude has taken some remarkable turns, as the young couple who appear for the first time and say, "We are honest; we are leveling with you; the girl is pregnant, now what can you do about it?" All this does not seem irregular or improper, and the young couple have claimed complete knowledge, invulnerability and savvy, not realizing that they are downright stupid and selfish.

The doctor can accept but not condone, can advise without assuming *locum parentis* status, can assure that a state of celibacy is not necessarily unhealthy, that a substitute for marriage and certainly promiscuity can be unhealthy. Morals and morality are the concern of the physician when a grave risk to mental and physical health is likely to be compromised, and this is a strong likelihood, when loose or demanding, strong or transient sexual relations are practiced. Perhaps the current deluge of printed pornography, sexual perversion, cannibalism, torture and complete filth is an index of something. It surely does not signify anything good or wholesome, and one cannot avoid encountering it.

The "menopause" era now receives the full treatment by many symposia, conversations and publications. Is it a deficiency disease or, as stated, a physiologic era? It is both. Gonadal senescence, somatic aging and the exigencies of four or five decades of living certainly can explain mild inchoateness and anxiety. A beginning statement, later supported by facts and full discussion, can allay the fear that the end of the reproductive life is also the end of the sexual life and productive life. This discussion will embrace early life, marriage or not marrying, children or no children, finances, and perhaps the presence of an attractive female secretary in the husband's office.

It should be noted that time and nature make demands on the male, with the added burden of being, classically, the provider. An unhappy, contentious, selfish female will probably remain so. A change of life would be welcome by all. A provident, happy industrious wife who had and does have pleasurable sexual intercourse will continue in healthy fashion to live a happy life. It is quite likely that both of these individuals will receive estrogen-progesterone, one or both, therapy. These hormones do have beneficial somatic effects and indirectly assure comfortable intercourse after the menopause. They hardly hold out the hope of infinite youthfulness.

There are, unfortunately, far too few competent marriage counselors, and an inept counselor leads only to further discord. Ideally, every physician's office should be a cancer detection center, a family planning center and an office for family counseling. Actually, it is possible for some workable degree to be attained. The acute, critical situations can be recognized, evaluated and often treated. If the person or persons are psychotic, hostile or uncooperative, they can be treated with dignity and advised to seek help and actually referred to one treating such special problems.

An obstetrician on the faculty has unusual opportunities to impart information to medical students. The student is more mature, has chartered a more purposeful undergraduate course, has

aims and ideals that may or may not be present in the general student body, and is likely to be married. The teacher also has the usual road blocks of strict curriculum, research endeavor, patient demands and the myriad assignments to school and hospital. Unless a definite topic and time allotment are prescribed, the whole matter of human sexuality and family counseling will be incompletely covered. Thus the student who has worked hard and consistently is taught the anatomy of sex but likely has less information and experience regard the human sexual relationship than some of his fraternity brothers. This student probably needs help and should have it, for his family's sake and security and, equally important, the opportunity for him to pass on much needed information to his patients.

Perhaps it would be helpful if one could print reliable guidelines for successful and happy sexual relations; a developing technique for achieving satisfaction; a certain course to be followed; a play by play description. But is not the spontaneous, the normal, not necessarily the accepted, more likely to be rewarding than the planned, the meticulous, the studiously followed approach to something that should be wholesome, reciprocal and elevating? Sexual relations is not a spectator sport; even the sometimes dour Supreme Court of the United States has ruled that the bedroom is privy.

Addendum

There are books that can be helpful; a good list is printed in *Marriage Counseling in Medical Practice* by Nash, Ethel M., Lucie Jessner and D. Wilfred Abse. 1964. Chapel Hill: The University of North Carolina Press. A good reference treatise. Others:

For physicians:

Calderone, Mary S. (ed.). 1964. *Manual of Contraceptive Practice.* Baltimore: Williams and Wilkins Co.

Stone, Abraham, and Lena Levine. 1956. *The Premarital Consultation.* New York; Grune and Stratton.

Van de Velde, Theodoor H. 1950. *Ideal Marriage.* New York: Random House.

For patients:

Baruch, Dorothy W., and Hyman Miller. 1962. *Sex in Marriage: New Understanding.* New York: Hoeber Medical Division, Harper and Row.

Calderone, Mary S. 1960. *Release from Sexual Tension.* New York: Random House.

Greene, Carol. 1964. *Sex and the College Girl.* New York: Dial Press, Inc.

To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual and immediate attention.

THE WEST VIRGINIA STATE MEDICAL ASSOCIATION

Announces a Postgraduate Course in Chest Disease

"Wheezing, Coughing and Shadows--Do's and Don'ts"

(A Day of Case Presentations of Pulmonary Disease)

Charleston Memorial Hospital
3200 Noyes Avenue, S. E.
Charleston, W. Va.

9:30 A.M. to 4:00 P.M., Sunday, January 26, 1969

Co-Sponsors: West Virginia Thoracic Society (Medical Section of the West Virginia Tuberculosis and Health Association); The West Virginia University School of Medicine; and Charleston Memorial Hospital.

Objective: To review the older and discuss the newer concepts in the diagnosis and management of pulmonary diseases.

Methodology: Patients with pulmonary disease will be presented and discussed *informally* by faculty and participants.

Faculty: John L. Guerrant, M.D., Professor of Medicine and Head of Allergy and Pulmonary Diseases, University of Virginia School of Medicine, Charlottesville; Charles E. Andrews, M.D., Provost of Health Sciences, and Professor of Medicine, West Virginia University; and other members of the WVU Department of Medicine Faculty; local physicians and surgeons.

Registration Fee: $10.00 (Including Lunch)

AAGP Credit Applied for

Note: The Kanawha Medical Society extends a cordial invitation to visiting physicians and their wives to attend its annual dinner dance and installation of officers at The Charleston House on Saturday, January 25, beginning at 7 P.M. Reservations for this function, at $10.00 *per person,* may be made by completing the form below and mailing it, along with check, to **West Virginia State Medical Association, P. O. Box 1031, Charleston, W. Va. 25324. Check should be made payable to "West Virginia State Medical Association."**

West Virginia State Medical Association
Charleston, W. Va.

Gentlemen:

Please register me for the pulmonary disease course on Sunday, January 26. My check in the amount of $_____ (enclosed) also includes reservations for _____ persons at the Kanawha Medical Society Dinner Dance on Saturday, January 25 at The Charleston House.

Name (please print)	*Type of Practice*
Street or Post Office Box	*City*

A message from . . .

The President

COMMUNICATION WITH SAMA

It gives me a great deal of pleasure to announce that a new program began last month. Mr. Ralph Greene, President of the West Virginia University Chapter of the Student American Medical Association, asked to have some speakers from the State Medical Association for the purpose of discussing different aspects of the practice of medicine in the State. This program was approved by our Council, and the first speaker was Dr. Maynard P. Pride, President Elect of the Association. Doctor Pride spoke to the students as well as interns and residents concerning the structure of the West Virginia State Medical Association.

The SAMA chapter also has requested discussion of the pros and cons of practice in West Virginia, opportunities, etc. These subjects will be worked over in future monthly meetings. I will have the privilege of addressing the group in February. I am sure that this type of program will be beneficial to our State in enticing the students graduating from our medical school to locate in our State.

At the recent AMA Clinical Convention in Miami Beach, which I attended, certain subjects were brought up that will be discussed in the future. One of the resolutions which I felt of great importance was in regard to the utilization of paramedical personnel. It is of great importance that the contractural agreements which remove services of medical personnel from the physician's supervision be opposed. Again emphasized was the need to have a representative or representatives of the medical staffs of our hospitals on the governing bodies of these hospitals.

I attended the Reference Committee meeting which was concerned mostly with joint accreditation of hospitals. It was emphasized that the rights of the medical staff should not be abridged. The accreditation of a hospital would be in jeopardy if this was done. New standards for accreditation will be published, probably in May, 1969.

In conclusion, I would again like to emphasize the need for all physicians to be concerned with the new bills relating to medicine that will be presented during the 1969 session of the West Virginia Legislature. All physicians should feel free to contact the State Headquarters Office in Charleston, or the Legislative Committee for any comments.

Richard W. Corbitt MD.

Richard W. Corbitt, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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EDITORIALS

HEART PROTECTION THROUGH PHYSICAL ACTIVITY

Elsewhere in this issue of *The Journal* may be found an article by Wilhelm Raab, M. D., "Fundamentals of Heart Protection Through Physical Activity." Doctor Raab has worked extensively on the physiology of exercise for many years and writes authoritatively. He is an ardent advocate of the value of physical exercise on the heart and firmly believes that exercise is of "great therapeutic and rehabilitative value in cardiac patients." He stresses the fact that physical training causes a slow heart rate, and emphasizes the important cardio-protective mechanism this affords. It probably should be pointed out, however, that a considerable amount of physical exercise indeed is required to establish a significantly slow pulse rate.

He stresses also the importance of the intracellular electrolyte balance, and mentions the importance of this balance (high potassium and low sodium) so far as normal myocardial activity is concerned. He believes that local hypoxia is associated with loss of potassium ions, and this is responsible for much of the abnormal function and structure of the heart, which includes the formation of multiple foci of necrosis. He states that the administration of potassium, especially associated with insulin and glucose or aspartic acid, has been found to correct functional cardiac disturbances and prevents the development of necrotic lesions. This statement would no doubt be challenged by many workers, who definitely feel that it never has been unequivocally shown that the administration of the above named substances have proved to have any clinical value.

Doctor Raab does not imply that physical training is a panacea for all cardiovascular disorders. He is quite fair in his appraisal of the lack of influence of exercise on hypertension and also on atherosclerosis. He points out that although men who take active physical exercise usually have a somewhat lower systolic blood pressure than do those who lead a sedentary life, nevertheless, physical training cannot be regarded as an important factor in reducing pathologically elevated blood pressure. He believes also that there is no convincing evidence that physical training exerts any anti-therogenic effect. In essence, he believes that the most important effect of physical training on the coronary vascular system is the growth and opening of new collaterals of the capillaries of the cardiac musculature.

Doctor Raab's article is timely and stimulating. Although he stresses physical exercise as a protective measure, nevertheless, what he writes can be applied to those who have suffered a coronary insult. There was a time, not too long ago, that these individuals were urged strongly

to participate only in a modicum of physical exertion. The patient was cautioned, for example, under no circumstances to hurry to catch a street car. This has all been changed. The modern concept is that well regulated daily exercise is beneficial to those who have, or have had, any coronary disease. Although physiologists are hard pressed to explain scientifically the value of physical exercise, it does seem that there is rather good evidence that it is of benefit to those who suffer from coronary vascular disease.

CONFERENCE ON PG MEDICAL EDUCATION

In November, more than 100 representatives of some 45 state medical societies, including the West Virginia State Medical Association, gathered in Chicago to exchange views on the thorny problem of continuing medical education.

Under the guidance of the AMA's Medical Education Division, the conferees grappled with such factors as motivation, evaluation, organization and methods, financing and the role of the state medical societies in this important field.

Participants in the National Conference of State Medical Association Representatives on Continuing Medical Education were intrigued by:

—The Indiana Medical Society's success in obtaining a $3 million appropriation by that state's Legislature for continuing education.

—The Oregon Medical Association's efforts to set educational standards for its members.

—The AMA's own proposal to reward physicians by presentation of certificates for successful completion of postgraduate courses and participation in other scientific activities.

Many of the participants expressed the fear that unless doctors take it upon themselves to "keep up," government will find some solutions. There was also a widespread view that since such necessary "hardware" as television facilities and computers do not come cheap, doctors are going to have to call upon sources outside the profession to help meet the costs.

One study group went so far as to adopt a resolution advising the medical societies to seek outside financial help, including tax funds as Indiana did. The reasoning seemed to be that since medical service benefits the public, then the public should assume a role in enhancing the quality of medical service. There were a few nays from a minority which regarded as amoral public subsidization of a relatively affluent segment of society.

There is, of course, something to be said for both positions. In a way, professions have been relying on public subsidy for years. One might investigate for example, the differential between the tuition paid by a medical student at a state operated medical school today and the actual cost to the state of educating him. Were it not for this type of subsidy, the man who today is "Doctor Smith" may well have been "Mr. Smith."

And the Regional Medical Program, which has a significant role in medical education in many states, is financed by tax dollars.

This question no doubt would ignite debate at wherever doctors gather. It seems certain, though, that continuing education in the future is going to cost a great deal more than it has in the past.

Perhaps eventually economics will demand that the public assume a greater share of the burden.

Smoking Affects Whole Family

Children living with an adult who smokes were sick more frequently than youngsters who live in homes of nonsmokers, reports a research team headed by Dr. Paul D. Cameron, Assistant Professor of Psychology at Wayne State University, Detroit.

Doctor Cameron's survey revealed that children exposed to tobacco smoke have respiratory diseases about twice as frequently as those in nonsmoking families.

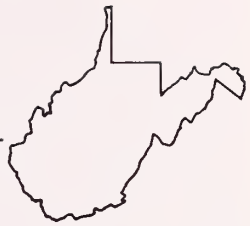
In addition, the study found that the more smoke the youngsters were exposed to, the greater their chances of becoming ill. A similar study conducted in Denver two years ago came to the same conclusions. The more recent survey of 727 Detroit families takes the findings a step further. It discounts the effects of air pollution on the subjects.

Air pollution is recognized as being harmful to the respiratory systems of children. Detroit ranks as the ninth smoggiest city in the United States, while Denver comes in far down the list, at 27th.

Thus, according to Doctor Cameron, his survey shows that background pollution does not mask the effects of tobacco smoke on the young. In other words, smoking parents cannot say that the air is so dirty that their smoking will not make any difference to the health of their children.—*Today's Health.*

Expenditures per scientist require large outlays: It costs the pharmaceutical industry an average of $32,300, with several companies spending more than $40,000 a year in laboratories, equipment, salary and overhead, to keep just one research scientist on the job. A more sharply focused comparison shows expenditures of $76,700 per doctoral-level research scientist.

GENERAL NEWS



Fall Meeting of the Council In Charleston on Nov. 17

The fall meeting of the Council was held at The Daniel Boone Hotel in Charleston on Sunday, November 17, 1968, with the Chairman, Dr. Richard V. Lynch, Jr., of Clarksburg, presiding.

Doctor Lynch introduced the following new members of the Council who were elected during the Annual Meeting at The Greenbrier in August: Drs. William T. Lawson of Fairmont, A. Thomas McCoy of Charleston and Harold Van Hoose of Man. Also attending the meeting was Dr. Charles E. Andrews, Provost of Health Sciences at West Virginia University.

The Council considered the following two recommendations which had been referred to that body by members of the 1968 Nominating Committee:

(1) That 60 days prior to the Annual Meeting the executive secretary be instructed to notify the secretary of each component society those offices to be filled at the Annual Meeting and ask for those recommendations to the Nominating Committee, listing qualifications, pertinent data and willingness to serve.

(2) We recommend that a meeting of the Nominating Committee be an open session and that sponsors and interested parties be encouraged to attend. Following full and appropriate discussion the Nominating Committee will go into executive session to carry out their designated duties.

Following discussion, the Council unanimously approved the recommendations submitted by the Nominating Committee.

Publication Committee Member Reelected

Dr. E. Lyle Gage of Bluefield was reelected a member of the Publication Committee for a term ending December 31, 1975. Doctor Gage is a Past President of the State Medical Association.

Liaison with SAMA Chapter

Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, reported that the officers and members of the West Virginia Chapter of the Student American Medical Association had expressed a desire to develop a program of increased liaison with the State Medical Association and its component societies.

In a letter addressed to Doctor Corbitt, the President of the WVU Chapter proposed that a series of programs and discussions be sponsored at the Medical Center for the purpose of discussing the advantages of medical practice in West Virginia as well as the trends of practice in the State including specialization, general practice and group practice. The officers of the Chapter proposed in the letter that meetings be arranged on a monthly basis at the Medical Center with physicians from throughout the State as speakers.

The Council unanimously approved the proposed program and instructed the Executive Secretary to work closely with the officers of the WVU Chapter in arranging a series of programs. The Council also recommended that the program be expanded to include the interns and residents at University Hospital.

Report of Legislative Committee

Doctor Holroyd reported that it is likely there will be a number of bills introduced during the 1969 session of the Legislature which will be of interest to members of the Association.

He said a bill had been drafted relating to a reportable disease law which would make certain medical disorders reportable by the treating physician to the Department of Motor Vehicles for its use in determining the eligibility of the person or persons being treated to operate an automobile.

Doctor Holroyd said the members of the Executive Committee had studied the bill and submitted a list of suggested revisions to the Legislative Interim Committee responsible for its preparation. He said the staff of the American Medical Association's Committee on Medical Aspects of Automotive Safety had been consulted and the Secretary had forwarded valuable information pertaining to the bill.

Doctor Holroyd also said a bill had been drafted which would establish a Board of Examiners of Psychologists. The Council voted to refer the bill to the officers of the Section on Neurology, Neurosurgery and Psychiatry and the West Virginia District Branch of the American Psychiatric Association for study and report back to the Council.

Doctor Holroyd reported it is likely the Medical Licensing Board will have introduced a bill which would amend several sections of the Medical Practice Act. He said the bill was in the process of being drafted and would be ready for study by the Legislative Committee and Council prior to the time the Legislature convenes in January.

Third-Party Programs

Dr. Harry S. Weeks, Jr., Chairman of the Medical Economics Committee, and Dr. George R. Callender, Jr., outlined the activities of the Association and its

Committees with reference to the Workmen's Compensation and Department of Welfare programs.

Doctor Weeks reported that the Department of Welfare had adopted new guidelines with reference to reimbursement to physicians for treatment of welfare patients. He said he believed that most physicians throughout the State were pleased with the new arrangement and he assured members of the Council that officials of the Welfare Department were making every effort possible to reimburse the physicians on the basis of their usual and customary charges.

Doctor Callender reported that a bill was passed during a special session of the Legislature in September which gave the Workmen's Compensation Commissioner the authority to establish and alter from time to time a schedule of maximum reasonable amounts to be paid physicians and others rendering treatment to injured employees. He said the word "reasonable" which was inserted in the bill at the last minute could be of significance according to Mr. William E. Mohler, Attorney for the Association.

He said that he and Mr. Mohler had appeared before the Senate and House Judiciary Committees in opposition to the bill. The proponents of the bill were the AFL-CIO, West Virginia Manufacturers Association, West Virginia Coal Association, UMW and representatives of several large industrial plants.

Committee to Evaluate Scholarship Program

Doctor Corbitt said he had appointed Dr. Kenneth G. MacDonald to serve as Chairman of a Special Committee to Study and Evaluate the Scholarship Program of the State Medical Association. Other members named were Drs. F. Lloyd Blair of Parkersburg, Robert Bess of Piedmont, J. C. Huffman of Buckhannon, Thomas P. Long of Man and Stephen Ward of Wheeling.

He pointed out that the House of Delegates during the 1968 meeting adopted a resolution citing the need for such a study and authorizing the President to name the members of the Committee.

Regional Medical Program

Doctor Corbitt also announced that he had appointed the following three physicians to serve as members of the Advisory Committee to the Regional Medical Program for Heart Disease, Cancer and Stroke: Dr. Maynard P. Pride of Morgantown (one-year term); Dr. Richard G. Starr of Beckley (two-year term); and Dr. Richard V. Lynch, Jr., of Clarksburg (three-year term). Dr. Halvard Wanger was named as alternate for the Association.

New AMA Field Representative

It was reported that Mr. James S. Imboden had been assigned as AMA Field Representative for West Virginia effective December 1. His office will be located in Columbus, Ohio, and he also will serve three other states. He replaces Donn Larson who served in that position for several months.

The following members of the Council were present:

Dr. Richard V. Lynch, Jr., of Clarksburg, Chairman; Dr. Richard W. Corbitt of Parkersburg, President; Dr. Maynard P. Pride of Morgantown, President Elect; Dr. George R. Callender, Jr., of Charleston, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Seigle W. Parks of Charleston, Councilor at Large; Drs. Harry S. Weeks, Jr., of Wheeling; William T. Lawson of Fairmont; George A. Curry of Morgantown; S. Elizabeth McFetridge of Shepherdstown; Robert W. Bess of Piedmont; A. Kyle Bush of Philippi; Andrew J. Weaver of Clarksburg; R. L. Chamberlain of Buckhannon; William E. Gilmore of Parkersburg; William L. Neal of Huntington; A. Thomas McCoy of Charleston; Worthy W. McKinney of Beckley; and Harold Van Hoose of Man; and Mr. William H. Lively of Charleston, Executive Secretary; and Mr. Edward D. Hagan of Charleston, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. George F. Evans of Clarksburg, Editor of *The Journal*; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; and Dr. Charles E. Andrews of Morgantown, Provost of Health Sciences at West Virginia University.

Stoneburner Lecture Series At MCV in February

Dr. Douglas D. Bond of Cleveland will be the guest lecturer for the 22nd Annual Stoneburner Lecture Series at the Medical College of Virginia in Richmond, February 20-21.

The title of this year's program is "Psychiatry in Medical Practice."

Doctor Bond is Professor and Chairman of the Department of Psychiatry and Former Dean of the School of Medicine at Case-Western Reserve University School of Medicine.

Other speakers will include:

Dr. Stanley L. Block, Associate Professor of Psychiatry at the University of Cincinnati College of Medicine; Dr. Ewald W. Busse, Professor and Chairman of Psychiatry, Duke University School of Medicine; Dr. Luther Christman, Professor and Dean of the School of Nursing, Vanderbilt University; Dr. John A. Ewing, Professor and Chairman of Psychiatry, University of North Carolina School of Medicine; Dr. David R. Hawkins, Professor and Chairman of Psychiatry, University of Virginia School of Medicine; and Dr. Marc H. Hollender, Professor of Psychiatry, University of Pennsylvania College of Medicine.

Dr. William W. Jepson, Chief of Psychiatry, Hennepin County General Hospital, Minneapolis, Minnesota; Dr. Zigmund M. Lebensohn, Director of Psychiatric Services, Sibley Hospital, Washington, D. C.; Dr. Heinz E. Lehmann, Clinical Director, Douglas Hospital, Verdun, Quebec; Dr. Milton Rosenbaum, Professor and Chairman of Psychiatry, Albert Einstein College of Medicine, New York City; and Dr. Melvin Sabshin, Professor and Chairman of Psychiatry, University of Illinois College of Medicine.

Additional information may be obtained by writing to the Continuing Education Department, Box 91, Medical College of Virginia, Richmond, Virginia.

State Health Director Discusses Measles Immunization

Convincing physicians of the importance of measles vaccination and persuading people in some areas to be immunized against measles have been two of the biggest problems in attempting to eradicate the disease, State Health Director N. H. Dyer stated in a recent issue of the State Health Department's weekly bulletin, the "State of the State's Health."

He said that Public Health Service officials still hope to fulfill a prediction that measles will be virtually eradicated by 1970. They expect about 6,500 cases in the United States in 1969 and 1,000 to 2,000 in 1970.

Thus far, the State Health Department's Vaccination Program has conducted measles campaigns in 43 counties in the State. Campaigns are scheduled in four additional counties in the near future, while eight counties have not been scheduled.

Doctor Dyer pointed out that West Virginia had 14,872 reported cases of measles in 1965, some 5,580 cases in 1966, and 1,486 cases in 1967. West Virginia has a cumulative total of 308 reported cases of measles through 1968 up to December as compared with 1,444 cases for the same period in 1967.

"The success in eradicating measles that has thus far been attained in our State can be attributed to the local health departments and the private physicians in our communities," commented Doctor Dyer. "This effort has been supplemented by thousands of volunteers in the counties who have conducted mass campaigns."

Doctor Dyer reported that local health departments have administered over 117,000 doses of measles vaccine. "In spite of this effort and the encouraging decline in measles," he said, "there are still 42,000 susceptible children in the one through ten age group in our State. At our present birth rate, we can expect an additional 29,000 newborn susceptible children each year."

The vaccination program in the near future plans to contact the eight counties that have not had campaigns and, where the need exists, conduct follow-up campaigns in other counties to increase the level of immunization.

"It is interesting to note that without mass immunization programs, it took 40 years to control diphtheria and whooping cough—with mass campaigns it took 10 years to control polio," Doctor Dyer said.

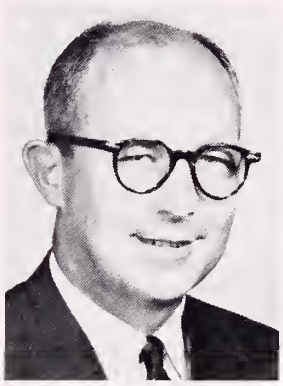
"The job of curtailing measles as well as polio, diphtheria, whooping cough, tetanus, and smallpox is a continuous effort, the health official said. "With this continuous effort and close cooperation from the local level, we feel certain that we will realize our goal of the practical eradication of measles in the near future."

Amblyopia Affects 1 in 20 Children

One in every 20 pre-school children in the United States is affected by amblyopia and other vision problems, according to the National Society for the Prevention of Blindness. The Society says many can be corrected if discovered and treated early.

WVU Medical Students To Hear State Physicians

The West Virginia University Chapter of the Student American Medical Association has inaugurated a series of monthly programs to establish better communication with physicians in private practice in West Virginia.



Maynard P. Pride, M. D.

Ralph Greene, President of the SAMA Chapter, worked with Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, in arranging the details.

Dr. Maynard P. Pride of Morgantown, President Elect of the State Medical Association, spoke to medical students, interns and residents on December 11 as the first speaker in the series. Doctor Pride is a surgeon and also serves as a Clinical Associate Professor of Surgery at the WVU Medical Center.

SAMA members reportedly believe that more WVU Medical School graduates would locate their practices in the State if they had more firsthand knowledge about medical practice in West Virginia.

"To get an overall view, we'll have as speakers physicians from all areas of the State," according to Mr. Greene.

Programs will cover, among other things, the needs of medicine in West Virginia; the advantages and disadvantages of practice in West Virginia; and the trends of practice in the State, including specialization, general practice and group practice.

Breast Cancer Conference In Washington

The National Conference on Breast Cancer will be held at the Shoreham Hotel in Washington, D. C., next May 8-10.

Sponsors are the American Cancer Society and the Cancer Control Program of the U. S. Public Health Service.

The meeting is for physicians and allied scientists, and it will present a multidisciplinary review of the breast cancer problem in the United States. Coverage will be given to epidemiology, etiology, detection, diagnosis, management and control measures.

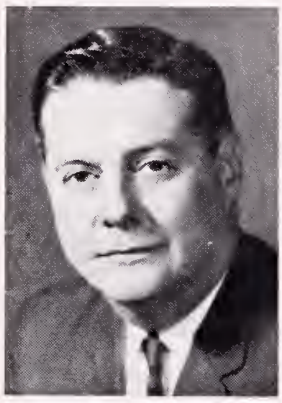
There is no registration fee, and advance registration is requested.

Additional information may be obtained by writing to Dr. Roald N. Grant, National Conference on Breast Cancer, American Cancer Society, 219 East 42nd Street, New York, New York 10017.

Project Hope May Add Second Ship

Project HOPE may add a second hospital ship to its medical teaching and treatment programs.

However, this plan is contingent on the end of the war in Vietnam, according to Dr. William B. Walsh, Founder, President and Medical Director of Project HOPE.



William B. Walsh, M. D.

The prospect of adding a sister ship to the S. S. HOPE was discussed in Project HOPE's annual report, which was released recently.

"We have made initial provision for the expansion into a second vessel," according to Doctor Walsh. "We have received written indication from the Department of Defense that they would look with favor upon our request for an additional hospital ship after the cessation of hostilities in the Far East."

Doctor Walsh went on to say that the need for a second ship is underscored by the 24 invitations Project HOPE now has for a visit of the hospital ship. Since its christening in 1960, the S. S. HOPE has conducted programs in South Vietnam, Indonesia, Peru, Ecuador, Guinea, Nicaragua, Columbia, and now Ceylon.

Project HOPE is a non-profit organization founded 10 years ago. Its purpose is to help raise the level of medical education in developing nations. Staffed with volunteer American doctors and other health personnel, the ship visits developing nations at their invitation for periods of 10 months or more.

Brashear PG Course in Anatomy At MCV, Jan. 28-31

The Alton D. Brashear Postgraduate Course in "Head and Neck Anatomy" will be held at the Medical College of Virginia in Richmond, January 28-31.

Two other programs in MCV's Continuing Education Program will be held in February and March.

The Stoneburner Lecture Series on "Psychiatry in Medical Practice" will be conducted February 20-21; and the Department of Radiology will sponsor a course in "Practical Radiology of the Skull, Spine, and Central Nervous System," March 4-8. The latter will be held in Williamsburg, Virginia.

Additional information about these programs may be obtained by contacting Dr. Charles M. Caravati, Director of Continuing Education, Medical College of Virginia School of Medicine, Richmond, Virginia.

New Association Members

Dr. Erogan Y. Baysal, 800 Fifth Street, Moundsville (Marshall). Doctor Baysal, a native of Turkey, received his M. D. degree in 1957 from the University of Istanbul. He interned at Providence Hospital in Seattle, Washington, and served residencies at Harrisburg General Hospital and Wayne County General Hospital in Eloise, Michigan. His specialty is internal medicine.

* * * *

Dr. Elena Cendana, 1205 Quarrier Street, Charleston (Kanawha). Doctor Cendana, a native of the Philippines, received her M. D. degree in 1959 from the University of Santo Tomas in Manila. She interned at the University of Santo Tomas Hospital and at St. Peter's Hospital in Albany, New York, and served residencies at hospitals in Tennessee, New York and Maryland. Her specialty is internal medicine.

* * * *

Dr. Graciano Cendana, Jr., Charleston General Hospital, Charleston (Kanawha). Doctor Cendana, a native of the Philippines, received his M. D. degree in 1958 from the University of Santo Tomas in Manila. He interned at Sister's Hospital in New Orleans, 1959-60, and served residencies at hospitals in Tennessee, New York and Maryland. He also received training in the Office of the Chief Medical Examiner in Baltimore. His specialty is pathology.

* * * *

Dr. Vann S. Taylor, Box 1101, Beckley (Raleigh). Doctor Taylor, a native of Bay City, Texas, was graduated from the University of Texas and received his M. D. degree in 1946 from the Tulane University School of Medicine. He interned at Milwaukee County General Hospital, 1946-47, and served a residency at Fitzsimons General Hospital in Denver, 1949-52. He served as a Lieutenant Colonel in the Medical Corps of the United States Army, 1947-55, and he was previously located at Corpus Christi, Texas. His specialty is physical medicine and rehabilitation.

* * * *

Dr. Richard A. Cuonzo, 302 Main Street, Parsons (Tygart's Valley). Doctor Cuonzo, a native of Mt. Vernon, New York, was graduated from the University of Arkansas and received his M. D. degree in 1944 from the University of Tennessee College of Medicine. He interned at Blodgett Memorial Hospital in Grand Rapids, Michigan, 1945-46, and served a residency at St. Vincent's Hospital in Toledo, Ohio, 1951-54. He served as a Captain in the Medical Corps of the United States Army and was previously located at Forrest City, Arkansas. His specialty is general surgery.

* * * *

Dr. Jose B. Caringal, Greenbrier Valley Hospital, Ronceverte (Greenbrier Valley). Doctor Caringal, a native of the Philippines, received his M. D. degree in 1951 from the University of Santo Tomas in Manila. He interned at the University of Santo Tomas Hospital and St. John's Hospital in Cleveland, Ohio, and served residencies at St. John's and St. Luke's Hospitals in Cleveland. He was previously located in New York City and his specialty is radiology.

Mental Health Representatives To Meet in Chicago

The mental health of children will be discussed at the American Medical Association's 15th Annual Conference of State Mental Health Representatives in Chicago, March 14-15.

There will be both plenary and workshop sessions with participants to include some of the key physicians who have been serving during the past two years on the task forces of the Joint Commission on Mental Health of Children, authorized by Congress in 1965.

Additional information may be obtained by writing to Dr. Walter Wolman, Director, Department of Mental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Hopemont State Hospital Gets New Chief

Dr. Jenaro A. Valencia has been named Acting Superintendent of Hopemont State Hospital near Terra Alta, succeeding Dr. Hilton Rocha.

Doctor Rocha is entering fulltime private practice in Terra Alta.

Doctor Valencia has been a staff physician at the institution for the chronically ill and aged and infirm. He received his M. D. degree from Cartagema Medical School in South America in 1957. He served a residency in surgery at Goldwater Memorial Hospital in New York City and completed a postgraduate course in internal medicine at Illinois Medical School.

Doctor Esposito First Vice President Of Southern Medical Assn.

Dr. Albert C. Esposito of Huntington was named First Vice President of the Southern Medical Association during the 62nd Annual Meeting of that organization in New Orleans, November 18-21.

Albert C. Esposito, M. D.

Doctor Esposito, who is a Past President of the West Virginia State Medical Association, also was installed as a member of the Executive Committee of the Association.

During the scientific session conducted by the Section on Ophthalmology, Doctor Esposito participated as a member of a panel discussion on "The Use of Innovar as an Adjunct to Local Anesthetics in Ocular Surgery."

Doctor Esposito has been active for many years in the affairs of the Southern Medical Association. He served for five years as Councilor from West Virginia and was named a member of the Executive Committee in 1963. He served as Vice Chairman of the Council, 1965-66, and served as Chairman of the Council and Executive Committee, 1966-67.

He served as Secretary of the Section of Ophthalmology and Otolaryngology, 1959-62, and was named Chairman of the Section in 1963.

More than 5,000 persons, including 3,000 physicians attended the meeting in New Orleans.

Looking Back 10 Years...

This picture was taken on October 5, 1958, at the Seventh Annual Press-Radio-TV Conference sponsored by the West Virginia State Medical Association. Left to right: Rep. Robert C. Byrd and Jennings Randolph, who at the time were Democratic Candidates for their first terms in the U. S. Senate; Dr. William L. Cooke of Charleston, who served as Moderator at the Conference; and Dr. George F. Evans of Clarksburg, then President of the Association.

West Virginia Births Continue Downward Trend

State Health Director N. H. Dyer commented on the 1967 vital statistics report released by the State Health Department in a recent issue of the "State of the State's Health." He noted that births to West Virginia residents continued a downward trend of 20 years, and that deaths remained about the same as in the past five years.

He reported that since 1953, although both the United States and West Virginia's birth rates have declined, West Virginia's rate has fallen below and stayed below the birth rate of the United States. From 1957 on, the crude death rate of West Virginia residents has been above that of the nation.

Illegitimacy has been on the rise in both West Virginia and the United States, Doctor Dyer said. From 1945 until 1965, (the latest figures available) West Virginia was above the national rate. In 1967, West Virginia recorded 2,501 illegitimate resident births—8.5 per cent of all births.

The report shows the change in the pattern of age at death since 1945. "Even in a brief space of 20 years, one is struck by the great reduction of deaths to persons under 45 years of age and the great increase of deaths to persons 65 years and older," Doctor Dyer stated "Interestingly enough, the per cent of all deaths to persons aged 45 to 64 remained constant."

Diseases of the heart continued to claim the greatest number of lives, both in the nation and in the state, the health official reported. Diseases of the heart accounted for almost 40 per cent of the total deaths in West Virginia. The 10 leading causes of death included diseases of the heart (7,644 deaths), malignant neoplasms (3,035 deaths), vascular lesions affecting central nervous system (2,081 deaths), accidents (1,221 deaths), pneumonia and influenza (622 deaths), certain diseases of early infancy (475 deaths), general arteriosclerosis (389 deaths), other bronchopulmonic diseases (331 deaths), diabetes mellitus (227 deaths), and other diseases of the circulatory system (273 deaths). Some 2,909 deaths were attributed to other causes.

Heart disease ranks as the leading cause of death for males in all age groups after 39, and for females beginning at age 60. It appears as a principal cause of death in all age groups from 15 to 99.

Malignant neoplasms are the leading cause of death for females age 30 to 59. The proportion of deaths due to malignant neoplasms is higher for females than males in all age groups except the 10 to 14 and 70 to 99 age groups. Doctor Dyer reported that since 1925 until the present, the death rates due to cancer were lower for West Virginia than for the United States. Nonetheless, the death rates due to cancer have been increasing more rapidly for West Virginia than for the United States.

The rate of deaths due to vascular lesions of the central nervous system has increased in West Virginia as it has in the United States but at a more rapid pace. From 1925 to 1955 West Virginia was below the United States, but since that time it has been above.

Accidents are the principal cause of death in each age group between 1 and 39, and appear among the five principal causes at all other ages except under 1 year and over 80 years.

With the exception of two early years, the residents of West Virginia experienced higher rates of deaths from 1925 to 1967 causes by influenza and pneumonia than the United States.

Doctor Dyer pointed out that a look at the infant deaths from 1945 to 1967 by age at death shows a great increase in the proportion of infant deaths that occur in the first day of life, and a concommitant decrease in the proportion that die after the first month of life.

From 1925 until 1963 the death rates due to diabetes were considerably lower for West Virginia than the United States. Since 1963, however, it appears that the death rates for diabetes in West Virginia are similar to those in the United States.

The rate of deaths due to diseases of the circulatory system has increased more rapidly for West Virginia than for the United States. Since 1960 West Virginia rates have been above those of the United States. Doctor Dyer said this increase may be due in a large measure to the increase in the total death rate.

The death rates due to tuberculosis in West Virginia closely resembled the death rate due to tuberculosis in the United States from 1925 until about 1953, when the West Virginia rate failed to decrease with the same speed as the United States.

Suicide appears as a principal cause of death in age groups 20 to 49. Of the 196 suicide deaths, 159 or 81.1 per cent were males.

Cardiac Care Nursing Course Scheduled at WVU

A nursing education course entitled "Nursing in Cardiac Care Units" will be held at the West Virginia University Medical Center, beginning January 6.

The three-week course is under the sponsorship of the West Virginia Regional Medical Program and the Medical Center.

Twelve to 15 registered nurses may take the course. There will be no tuition, and educational materials will be furnished free of charge. Hospitals sponsoring the nurses are expected to defray travel and subsistence costs.

Providing the instruction will be members of the staff of the Division of Cardiology and the nursing staff of the WVU Cardiac Care Unit. Considerable emphasis will be placed on the recognition of rhythm disturbances. Other topics will include the anatomy and physiology of the heart and circulation; the pathology of life-threatening heart diseases; pharmacology of important cardiovascular drugs; cardiopulmonary resuscitation; and nursing aspects of acute cardiac care.

Additional information may be obtained by contacting Dr. Robert J. Marshall, Division of Cardiology, WVU Medical Center, Morgantown.

PG Course in Chest Disease In Charleston

A postgraduate course in chest disease will be offered at Charleston Memorial Hospital in Charleston on Sunday, January 26, beginning at 9:30 A. M.

Sponsors are: the Committee on Medical Education and Hospitals of the West Virginia State Medical Association; the West Virginia Thoracic Society (Medical Section of the West Virginia Tuberculosis and Health Association); the West Virginia University School of Medicine; and Charleston Memorial Hospital.

The course is entitled "Wheezing, Coughing and Shadows—Do's and Don'ts (A Day of Case Presentations of Pulmonary Disease).

Dr. Joseph T. Skaggs of Charleston, Course Director, said the objective of the course will be to review the older and discuss the newer concepts in the diagnosis and management of pulmonary diseases. Patients with pulmonary disease will be presented and discussed.

Guest speakers will include Dr. John L. Guerrant, Professor of Medicine and Head of Allergy and Pulmonary Diseases at the University of Virginia School of Medicine; Dr. Charles E. Andrews, Provost of Health Sciences and Professor of Medicine at West Virginia University; and other members of the Department of Medicine at the West Virginia University Medical Center. Other physicians and surgeons will participate in the case presentations.

Registration fee for the course is $10, and application has been made to the American Academy of General Practice for accreditation. Any member of the West Virginia State Medical Association may attend.

The Kanawha Medical Society will conduct its annual dinner dance and installation of officers at the Charleston House on Saturday evening, January 25. Officers of the Society have invited all out-of-town physicians who will be coming to Charleston for the course to attend. Reservations may be made at $10 per person.

An announcement of the chest disease course and a registration blank appear elsewhere in this issue of *The Journal*. Additional information may be obtained by writing to: West Virginia State Medical Association, P. O. Box 1031, Charleston, W. Va. 25324.

AMA President Elect Speaks On Health Insurance

The need for more effective, economical and comprehensive voluntary health insurance was emphasized in a recent speech by Dr. Gerald D. Dorman, President Elect of the American Medical Association.

Continuing improvements in health insurance are necessary to help alleviate the financial burden stemming from rising medical costs, he said at the annual meeting of the Association of Life Insurance Medical Directors of America in St. Louis.

"We must achieve an understanding by the public that the multiplying factors of demand not only have stimulated increases in the cost of health care, but actually have forced the cost upward," he told his audience.

Heart Association Announces Film on Proper Diet

A film, entitled, "Eat To Your Heart's Content", has been announced by the West Virginia Heart Association.

The narrated film explores, in a light, bouncy fashion, the importance of a proper diet in reducing the risk of heart attack. The viewer is introduced to a typical, middle-aged American male who is having trouble keeping his weight down, and his wife, who would like to help him take off the extra pounds without taking all the pleasure out of his eating.

The film, which is 16mm color, sound, is approximately 13 minutes in length, and is ideal for showing at meetings of clubs, organizations, PTA's, etc. Any organization wishing to use the film free of charge, should contact the West Virginia Heart Association, 211 35th Street, S. E., Charleston, West Virginia 25304. Two or three weeks should be allowed for delivery. A free copy of the Heart Association's Film Directory may be obtained by writing to the same address.

New Mental Health Center In Washington

The nation's largest mental institution, Saint Elizabeth Hospital, Washington, D. C., will be converted to a model of modern mental health services, training and research by the National Institute of Mental Health.

The National Center for Mental Health Services, Training and Research will be headed by Dr. Sherman N. Kieffer, Assistant Surgeon General of the Public Htalth Service.

The new national center will have three divisions. One is the Saint Elizabeth Hospital-Division of Clinical and Community Services. In collaboration with the D. C. Department of Health, this divisions will operate the Area D Community Mental Health Center which includes much of Southeat Washington. It will also provide active treatment, care and rehabilitation services for the beneficiaries of Saint Elizabeth Hospital.

Heart Association Names Mr. Spruce

George W. Spruce, Jr., of Charleston, has been appointed Public Relations Director of the West Virginia Heart Association, succeeding Larry O'Brien, who has assumed a similar post in Iowa.

Mr. Spruce is a graduate of the Chicago Academy of Fine Arts and Morris Harvey College and has been associated with other trade and professional organizations.

PG Course in General Practice

The Cleveland Clinic Educational Foundation will offer a postgraduate course in "General Practice," February 5-6.

Registration fee is $25, and information may be obtained by writing to the Education Secretary at 2020 East 93rd Street, Cleveland, Ohio 44106.

Correspondence

DIVISION OF ANESTHESIOLOGY
West Virginia University
Medical Center
Morgantown, W. Va.

To the Editor:

Doctor Samet's article, "Emergency Treatment of Acute Pulmonary Edema" (The West Virginia Medical Journal, Vol. 64:442, November, 1968), assures me that the "grey gaspers" are receiving equal consideration with the "pink puffers" and the "blue bloaters."[1, 2]

I take exception, however, to Doctor Samet's lack of emphasis on positive pressure, or even ambient pressure, oxygen administration as a cornerstone of immediate treatment. While he mentions correction of arterial hypoxemia under the heading "removal of precipitating and aggravating factors," he neglects to convey the urgency of oxygen administration as an essential part of initial therapy. Instead, it is mentioned late in the discussion, and then only as a prophylaxis, following a consideration of minutiae such as the use of mecamylamine and dihydroergokryptine. It is important for students to realize that positive pressure oxygen administration is an *urgent initial* measure in the clinical management of acute pulmonary edema.[3, 4]

Allen E. Yeakel, M. D.
Associate Professor

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1. Morgan, William Keith C.: Irreversible Obstructive Airway Disease: Definition, Pathology, Etiology, West Virginia Medical Journal 64:288, August, 1968.
2. Russakoff, A.: Management of Acute Respiratory Failure in Patients with Chronic Obstructive Pulmonary Disease, ibid 64:350, Sept. 1968.
3. Cecil and Loeb-Textbook of Medicine, Beeson and McDermott Editors, Philadelphia, W. B. Saunders, 1967. p 593d, p 653d and p 1716a.
4. Current Therapy—1968, Howard F. Conn, Editor, Philadelphia, W. B. Saunders. p 167c, p 186a and p 756c.

Congress on Socio-Economics Of Health Care

The Third National Congress on Socio-Economics of Health Care will be held in Chicago, March 28-29.

The meeting is sponsored by the Council on Medical Service and the Division of Health Service of the American Medical Association.

Participants will attempt to identify the major issues and problems precipitated by growing complexity and specialization in our medical and social system. Special attention will be devoted to techniques for evaluation and assurance of quality; meeting the needs for health manpower; and effective financing of health services.

Additional information may be obtained by writing to Dr. Charles L. Hudson, Director, Division of Health Service, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Jan. 18-23—Am. Acad. of Orthopaedic Surg., New York.

Jan. 26-29—Soc. of Thoracic Surg., San Diego, Calif.
Feb. 9-10—AMA Cong. on Med. Ed., Chicago.
Feb. 18-22—Am. Col. of Radiology, Atlanta.
Feb. 26-March 2—Am. Col. of Cardiology, New York.

March 13-15—AMA-ABA Medicolegal Symp., Las Vegas.
March 15-19—Am. Acad. of Allergy, Bal Harbour, Fla.
March 21-22—AMA Rural Health Conf., Philadelphia.
March 28-29—AMA Cong. on Socio Economics of Health Care, Chicago.
March 31-April 2—Am. Assn. for Thoracic Surgery, San Francisco.

April 9-11—Maryland Medical, Baltimore.
April 13-17—Am. Assn. of Neur. Surg., Cleveland.
April 16-19—W. Va. Chap., ACS, White Sulphur Spgs.
April 18-20—Am. Soc. of Int. Med., Chicago.
April 20-23—W. Va. Acad. of Oph.-Otol., White Sulphur Springs.
April 21-23—Am. Acad. of Ped., Boston.
April 21-25—ACP, Chicago.
April 21-26—Am. Acad, of Neurology, Washington.
April 25-27—W. Va. Chapter, AAGP, Wheeling.
April 28-May 1—Am. Col. of Ob. & Gyn., Bal Harbour, Florida.
April 30-May 1—Am. Ped. Soc., Atlantic City.

May 5-7—Am. Gyn. Soc., New Orleans.
May 5-9—Am. Psychiatric Assn., Miami Beach.
May 6-7—Assn. of Am. Phys., Atlantic City.
May 12-15—Am. Urological Assn., San Francisco.
May 12-16—Ohio Medical, Columbus.
May 24-26—Am. Thoracic Soc., Miami Beach.
May 26-28—Am. Oph. Soc., Hot Springs, Va.

June 2-6—Am. Col. of Allergists, Washington.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.

July 11-12—Rocky Mtn. Cancer Conference, Denver.
July 13-17—AMA, New York.

Aug. 18-20—Am. Hosp. Assn., Chicago.

Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 6-12—ACS, San Francisco.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 11-15—Am. Col. of Prev. Med., Detroit.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

The West Virginia Medical Journal

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The Evolution of Modern Cardiology, Being in Some Measure The Experience of a Stethoscope (1908-1968)*

William S. Middleton, M. D.

In 1908, my Bowles model stethoscope was purchased from Edward P. Dolbey in Woodland Avenue, Philadelphia, for $4.50. It has served me faithfully and has witnessed great advances in cardiology through the span of 60 years. Such errors as have arisen from its use must be laid to faulty reception or interpretation on my part and not to defects inherent in the instrument.

This binaural stethoscope is the natural offspring of the monaural form devised by Laennec in 1816 (Figure 1). His naive account of its discovery, as translated, reads, "In 1816, I was consulted by a young woman labouring under general symptoms of diseased heart, and in whose case percussion and the application of the hand were of little avail on account of the great degree of fatness. The other method just mentioned (immediate auscultation) being rendered inadmissable by the age and sex of the patient, I happened to recollect a simple and well known fact in acoustics, and fancied it might be turned to some use on the present occasion. The fact I allude to is the great distinctness with which we hear the scratch of a pin at one end of a piece of wood, on applying our ear to the other. Immediately, on the suggestion, I rolled a quire of paper into a kind of cylinder and applied one end of it to the region of the heart and the other to my ear, and was not a little surprised and pleased to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than I had ever been able to do by the immediate application of the ear."

The impetus of Laennec's discovery to examination of the patient in general and the heart in particular cannot be overemphasized. Inspection and palpation were well established before his period. Percussion that had been neglected after Auenbrugger's enunciation of its principles (1761), had been restored to its appropriate place by Corvisart (1808). Mediate auscultation, however, was to forge the strongest link in advancement of knowledge of the cardiovascular system at the beginning of the nineteenth century. Singularly, Laennec manifested a restricted grasp of the significance of cardiac signs, while his comprehensive interpretation of pulmonary phenomena has stood the test of time.

The early observations of Stephen Hales on the arterial blood pressure of the horse (1711) lay fallow for many years. Actually his own studies were not published until 1733. Finally, in 1896, the several experimental models to determine the blood pressure gave way to a clinically practical sphygmomanometer (Riva Rocci) that vastly improved the earlier instruments of Marey and Potain. The anaeroid blood pressure apparatus gradually replaced the mercury manometer by reason of its more compact and convenient form. Korotkoff, in 1905, described the auscultatory phases, determined by the altered pressure of the cuff over the artery, as an accurate method of sphygmomanometry. This method is still employed. *The* stethoscope bears witness to the excesses that early attended the overenthusiastic deference to these determinations.

The Author

- **William S. Middleton, M. D., Dean Emeritus, University of Wisconsin Medical School, Madison, Wisconsin.**

*Presented before the second general scientific session of the 101st Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-24, 1968.

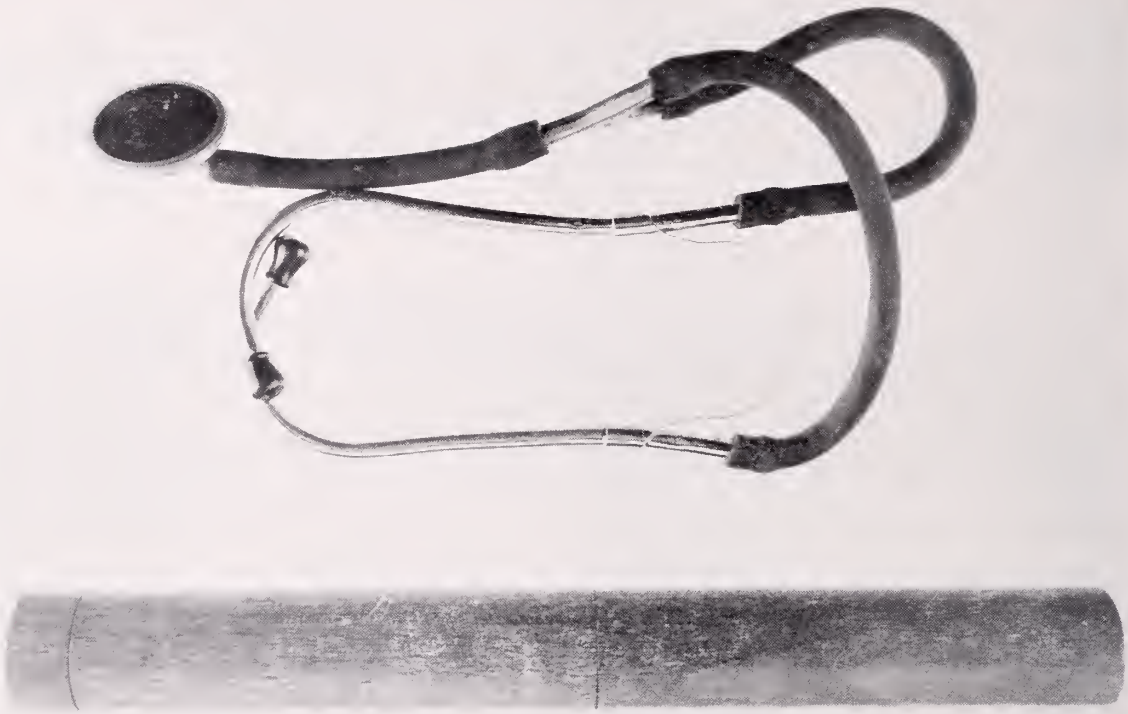

Figure 1. Stethoscopes: Laennec (vintage 1819) below; and Bowles (vintage 1908) above.

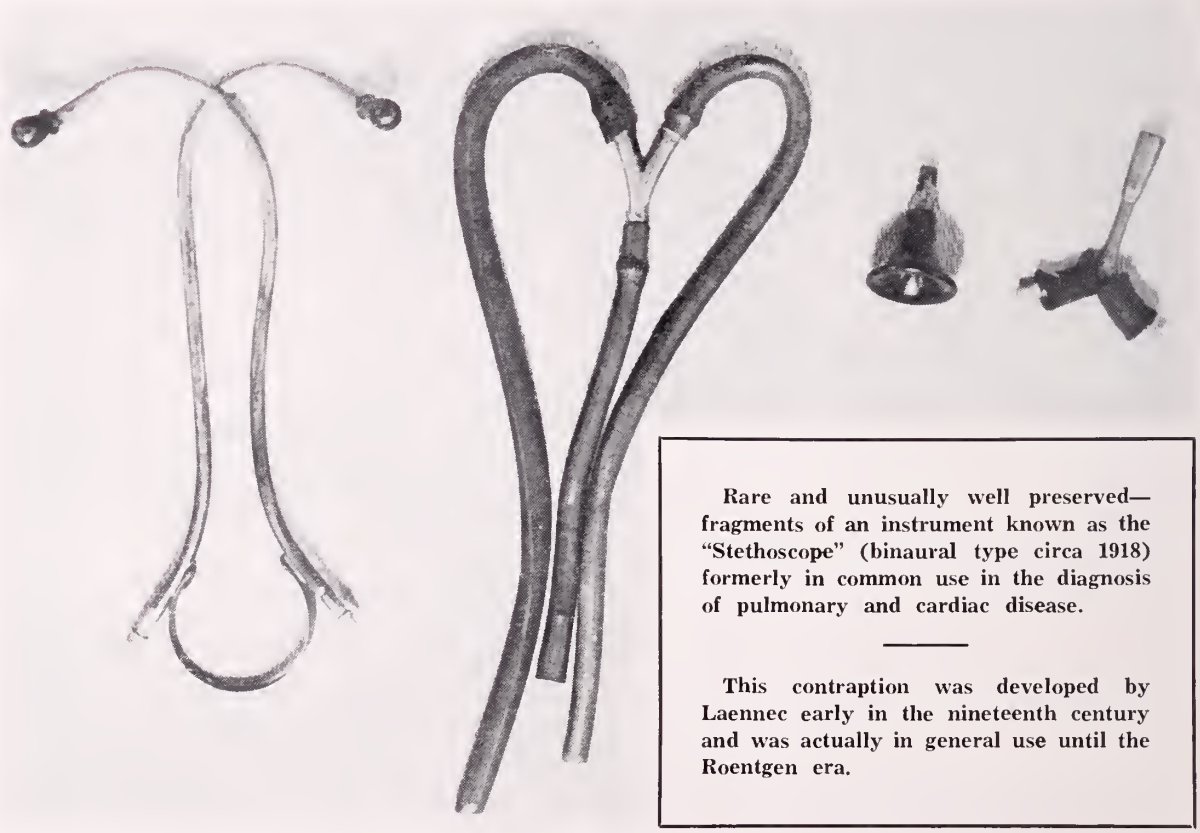

Figure 2. Sosman Exhibit: Peter Bent Brigham Hospital, Boston, Massachusetts.

Studies of the venous pressure were never as widely accepted for clinical purposes as those of the arterial blood pressure. Employing the indirect method with the instrument devised by Hooker and Eyster (1908), invaluable information of the capacity of the right heart to receive the returning blood may be derived. Direct readings of the venous pressure by venipuncture largely replaced the indirect method. In turn, central venous pressure determinations in the superior vena cava have superseded studies of the pressure in peripheral veins. Clearly such approaches bring Starling's curve of cardiac strain and overstrain into clinical focus.

For many years, medicine sought graphic methods of studying and recording the phenomena of movement of the blood in the heart and blood vessels. Marey (1860) had devised a polygraphic apparatus that would simultaneously record pulse waves and precordial activity. From his absorbing interest in cardiac arrhythmias (from 1880), Mackenzie evolved an ink polygraph. Although his monumental studies anticipate our Odyssey, they contribute a landmark in cardiology. From them, he was enabled to diagnose and prognosticate the simple from the grave arrhythmias—a detail that requires later attention.

In a lighter vein, as an intern in the Philadelphia General Hospital, I was interested in the observations of Dr. William Pepper, later Dean of the University of Pennsylvania School of Medicine, with the ink polygraph (1911). In response to my inquiry relative to its usefulness, with characteristic candor, he declared, "Middleton, it is the most useless waste of time in which I have ever indulged." Scarcely an invitation to my personal participation.

Meanwhile, a new development arose to eclipse polygraphy. Although Matteuci, Weller and others had appreciated the electrical potentials of muscle, including myocardial, contraction, Einthoven resolved the matter to a practical model for experimental and clinical investigation in the invention of a string galvanometer (1902). He termed the resultant procedure "electrocardiography," which gave a new dimension of accuracy to the clinical appraisal of cardiac conduction and myocardial disturbances. By this token, it truly revolutionized cardiology. When I came to Madison (1912), by a turn of fortune, a group of able physiologists (Eyster, Meek and Gasser) was engaged in fundamental studies of neuromyocardial conduction. In 1911, an Edelman electrocardiographic apparatus had been purchased for the Department of Physiology at a cost of $6050.98—a stupendous sum at that time. It paid splendid dividends, however, in the scholarly contributions of its users. An unusual Departmental technician, James Hipple, by his native ingenuity duplicated this apparatus for paired physiological experiments. The duplicate was shortly (1913-14) transferred to the Student Infirmary (Raymer House) for clinical application. Here under primitive conditions, I was initiated to the Einthoven triangle and the conventional limb leads for the orderly study of changing electrical potentials under various clinical conditions.

Two circumstances in relation to those exciting days are recalled. The electrodes, imported from Germany, were finely drawn glass threads coated with silver. With the onset of World War I, this source of supply was interrupted. Mr. Hipple's substitutes, while useful, never attained the delicacy of the original German product and the resultant electrocardiograms were quite coarse. The apparatus was housed in the basement and the wires for the leads were brought through the floor to a room above, where the patient rested on a cot. The electrocardiograms were developed in a dark room in the unheated basement. The less hardy observers required top coats if they wished to read the tracings before they were dry.

The year 1924 brought the distinguished Professor Willem Einthoven to Madison. Pains were

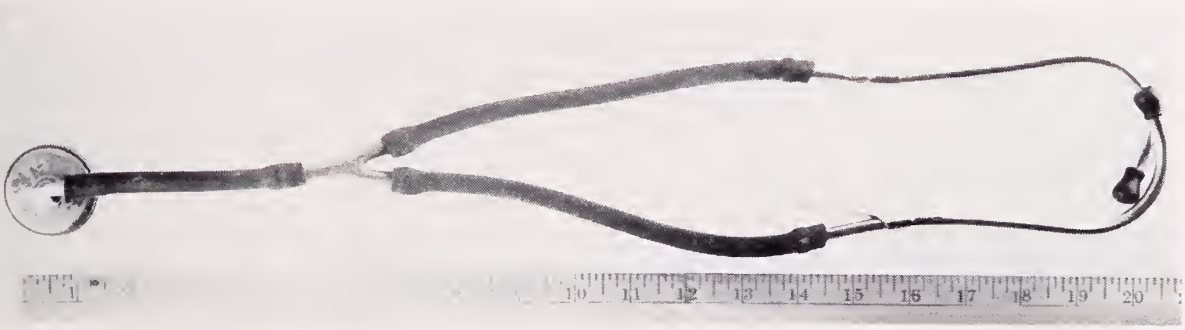

Figure 3. The maximal physician-patient distance for a proper examination.

taken to show him first our meager best. Having exhausted this prospect, he was taken to the Laboratories of Physiology in the basement of Science Hall. Thereupon he first removed his coat, then his waistcoat and finally his dickey. With a sigh of relief, he exclaimed, "Ah, this is home!"

With vast improvements both in the basic apparatus and in the techniques of electrocardiography, medicine today is infinitely better served in the evaluation of certain aspects of cardiac physiology and disease than a half century ago. Pipberger and Freis have evolved an interesting innovation in the computer field for mass interpretation of electrocardiograms. They have transferred electrocardiographic signals in analog form to the magnetic tape. The signals are then converted to digital form for automatic analysis by the electronic computer with an accuracy approximating 95 per cent. Telephone telemetry is an early prospect in this field. Retracing our steps, certain early differences have been reconciled; yet, to the traditionalist, Mackenzie's suggestion of "auricular paralysis" has a more distinctive physiological connotation than the atrial fibrillation of current acceptance (Lewis). James Heard related an interesting observation from Mackenzie, "I don't mind telling you, Doctor, I hae ta'en all the cream off it. Tomas can hae the rest." The note of caution, sounded by Frank N. Wilson, should always be borne in mind: "Electrocardiography is one of the most exact of diagnostic methods. Its potential value is great, but it is not being used to the best advantage. Electrocardiographic abnormalities are not diseases. They have no important bearing upon the life expectancy of the patient, or the extent to which his mode of life should be altered when there is a reasonable doubt as to the nature of the factor or factors responsible for them in that particular case."

Meanwhile, as the role of electrocardiography was increasing apace in clinical medicine, radiology afforded an added parameter of objectivity in the study of the heart and great vessels. The Wisconsin group, Bardeen, Eyster, Hodges, et al, directed attention to determination of cardiac size by teleoroentgenography. Accepting the technical limitations of the period (1912-20), they clearly discredited the cardiothoracic ratio in this relation and proved that the cardiac silhouette (teleoroentgenogram) in the postero-anterior projection, as measured by planimetry, is a function of body area and not of the height or of the weight alone. Their charts, however, based on this correlation, never gained wide favor. Eventually, Eyster and Kurtz utilized orthodiascopy for the more precise definition of the cardiac size (Kurtz 1937).

Meanwhile *the* stethoscope had traveled far and had had one disquieting experience. In the Spring of 1918, I was Battalion Medical Officer with the First Battalion, King's Own Royal Lancaster Regiment, Fourth Division of the British Expeditionary Forces. The Division was in reserve when the German attack of Good Friday was launched to broaden their front between Amiens and Arras. Details of the military action only indirectly concern the whereabouts of *the* stethoscope. With the German advance south of the Scarpe River, our flank became more exposed and my aid post in a shack behind the railroad bank was untenable. At the same time, the third wave of the German advance overran the Essex positions and the King's Own held the British front line of defense. To maintain contact with our Battalion, I moved forward and established communications.

In this movement, Sergeant Stanley, a stout North County man, overlooked or mislaid *the* stethoscope. I was forced to use a British issue instrument. In about a week, I was transferred to the American Expeditionary Forces. My dismay in leaving my British associates without *the* stethoscope obviously deeply impressed Sergeant Stanley. My surprise and relief knew no bounds when, after a few weeks, the military dispatch delivered this precious companion to me at the Central Medical Laboratory, Dijon, France. The accompanying letter from the Sergeant told of his discovery of *the* stethoscope in the possession of one of the stretcher bearers, who on sick call was listening to another British Tommy's chest with it.

Certain sophisticated physical refinements have added materially to the advancement of cardiology. As an example, phonocardiography has afforded a definition to cardiac sounds, normal and abnormal, beyond the range of the unaided human ear; but no clinician worthy of the name has substituted this elegant apparatus for his stethoscope. Under certain circumstances, it becomes a welcome ally in the more complete elucidation of an involved problem. Interesting is the healthy renaissance in the basic interpretation of cardiac auscultation that at times is so involved as to recall Justice Cardozo's characterization. "There is an accuracy that defeats itself by overemphasis of details." Ballistocardiography offers specific information, viz, the ejection thrust, that can be established by no other method. Still it has never captured the measure of clinical attention it deserves. Vector-

cardiography also is a technical approach that has not gained wide clinical acceptance. Just on the horizon is the prospect of the application of the ultrasonic Doppler principle to auscultation. The signals registered by the Doppler cardiophone bid fair to open a new acoustical world in the auscultation of the heart. The conventionalist may perhaps change his basic concepts, if this occurs.

The physical potentiality of radiology could not rest upon mere morphology. By kymography, movements of the heart borders were recorded (Moore), and invaluable information as to pathological changes in the myocardium and pericardium gained. The revolutionary movement, however, awaited cardiac catheterization, which brought factors that previously had been implied or measured indirectly, under more or less precise control. As early as 1905, Bleichroeder had passed a catheter into the arteries and veins of a dog and into his own veins; but these cursory observations were not actively pursued. These studies were not controlled by x-ray; but no adverse result attended the intravenous manipulations of catheterization. With Unger (1912), Bleichroeder utilized the femoral artery approach for injection of Collargol into the lower abdominal aorta for treatment of puerperal sepsis. Without knowledge of these earlier studies, Forssmann, in 1929, passed a catheter via the veins of his own forearm into the right atrium under the fluoroscope with a nurse holding a mirror for his guidance. Experiencing no discomfort, he then walked from the operating room to the x-ray department. In 1931, he opacified the heart chambers of a dog by injection of radiopaque material into the femoral vein. He could not, however, duplicate the result on himself. By intravenous injection of diodrast, Robb and Steinberg (1938) first visualized all chambers of the human heart.

The bridgehead had been established and expansion of basic information of the structural and hemodynamic processes of the heart has been monumental. A generation past, we were satisfied to classify congenital heart lesions as cyanotic, delayed cyanotic and acyanotic. Certain specific abnormalities were recognized; but, by and large, since there was no method of correction, the deficiency was not magnified by our ignorance. Now with the ability to enter any heart chamber or great vessel with an assurance (or abandon) undreamed of in an earlier period, not only are pressure readings momentarily available, but pressure gradients across valves give invaluable diagnostic data. Samples of blood taken from the several heart chambers and great vessels may be studied for oxygen content or pressure. Indicator dilution curves afford important information. The hemodynamics of the circulation may be directly measured. To cap these several parameters, cineangiocardiography has been developed to such a degree of technical excellence as to give definition to coronary as well as cardiac pathological lesions. Recently, other sophisticated physical principles have been adapted to clinical practice. Photoscanning with sodium pertechnetate Tc99m offers a ready method for the diagnosis of pericardial effusion. A halo surrounds the radioactive filled heart. In addition, the concentration of pertechnetate in the stomach affords a confirmatory detail in its abnormal separation from the similarly marked heart by the interposition of pericardial fluid. In some centers, injection of C_3131 has found favor in the definition of myocardial infarction.

With the support of these methods of precision from the chemical, physical and physiological laboratories, there should be a conscious effort to maintain those proved bedside methods that have stood the test of time. Confirmation of the clinical diagnosis of coronary arterial compromise by chemical, electrocardiographic and cineangiographic evidence is reassuring. On the other hand, a patient may die of coronary artery insufficiency without conclusive evidence from these sources. Conversely, severe grades of atherosclerosis may be demonstrated on cineangiography or at necropsy in patients who have no record of coronary artery insufficiency. These instances are exceptions to the rule. Enzyme studies on the blood have extended the earlier observations of leucocytosis and increased erythrocyte sedimentation rate in myocardial infarction. Without an iota of iconoclasm, each and every element of the newer cardiology is welcomed as a boon to the patient through the physician's clearer understanding of the problems involved.

Despite the vaunted progress in the knowledge of the physiology and pathology of the heart, diseases of the cardiovascular system still account for more deaths in the United States than those from all other causes. The partial containment of cardiopathic infections, as syphilis and rheumatic fever, has appreciably reduced the incidence of their crippling sequelae. Other infections, viz, viruses and fungi, have emerged as occasional etiologic threats. Overwhelming, of course, is the ascendency of the degenerative factors in cardiac pathology. Toward the prophylaxis and control of their contributing backgrounds with the common denominator of atherosclerosis, great efforts are being extended.

In the advance, the therapy of cardiovascular diseases has been almost as profoundly affected

as their diagnosis. Whenever cardiac problems present, digitalis is the sheet anchor of treatment. Its administration should be reserved primarily for the patient in failure or threatened failure. Certainly the distinction between right and left heart failure has no place in this decision. Digitalis is indicated in both. Much wasted effort has gone into discussion of the relative merits of the Galenical preparations and the glycosides of digitalis. My admonition is to learn and to gain confidence in two forms of digitalis, i.e., a promptly acting form for intravenous use and a slow actor for continuous or maintenance oral administration. Of one thing be assured, in spite of the representations of the detail man and the advertisements, if it be a potent digitalis product, there will be the inherent hazard of by-effects. In recent years, a high incidence of gynecomastia apparently has attended the use of glycosides of digitalis that had not been recorded with the leaf. Significantly, the levels of serum calcium and potassium are now receiving merited attention in patients receiving digitalis. The inotropic and chronotropic action of catecholamines are being weighed in the use of adrenergic drugs. The control of cardiac arrhythmias has been subjected to clearer pharmacological rules. Quinidine sulfate, although much maligned, still is an effective drug in our hands. Reserved for the control of atrial fibrillation or more serious ectopic arrhythmia, its prompt action (10-15 minutes by mouth) and its short duration of action (one and one-half to two hours) should govern its administration. In practice, doses of 200-400 mg. are given every two hours around the clock for 36 hours, or until normal sinus rhythm is restored. If there is no improvement in 36 hours, the drug is discontinued. If normal sinus rhythm has supervened, the dosage is first reduced and then the interval lengthened (by doubling the time), until it may be possible to eliminate the quinidine—or to fix a maintenance schedule. Procaine amide (pronestyl) is favored for the control of ectopic beats and ventricular tachycardia (250-500 mg. dose every four to six hours). Neosynephrine 0.5-1 mg. intravenously (Youmans) may have a dramatic role in the control of supraventricular tachycardia. Upon its administration, the sharp rise in blood pressure stimulates the carotid sinus with slowing of the heart. Lidocaine (Xylocaine) has earned an assured position in critical ventricular arrhythmias. The recommended loading dose is one mg. per kilo of body weight intravenously. Thereafter with careful monitoring, an intravenous drip is maintained at a rate not to exceed one mg./minute. Propanolol and diphenylhydantin (dilantin) are receiving extended study for the treatment of arrhythmia.

Cardiac edema to the point of anasarca ever has been a therapeutic target for physicians. My introduction to its control was by mechanical relief. Thoracentesis, paracentesis, Southey tubes and scarification of the scrotum and legs were commonplace. Within the last generation, the ground shifted, so that the verdict arose that the physician's care and ability are in reverse ratio to the frequency of his recourse to these devices. Sound physiological principles dictate his correction of such variable contributors to the caridac edema as are amenable to his management. Rest, low sodium intake and digitalis usually suffice to turn the tide. Interesting has been the displacement of time honored mercurial diuretics by hydrochlorothiazide (hydrodiuril), which latterly is being challenged by furosemide (Lasix) and ethacrynic acid. In the use of these diuretics, the electrolyte balance must be closely guarded.

Recent studies, largely by Lillehei and his associates at Minnesota, have seriously challenged the accepted management of shock. Reinforced by some basic observations of the response of the capitance vessels and the resistance arterioles to the increased sympathetic tone and increased levels of circulating catecholamines, they subjected a large series of dogs to controlled experimental myocardial infarction. Their results showed an advantage of phenoxybenzamine (dibenzaline), an adrenergic blocker, and corticosteroids, supplemented by sodium bicarbonate intravenously, over the vasopressor agents. In their hands, isuprel has a definite place in this situation. They subscribe to the long held physiologic principle of a decrease in the *effective* circulating blood volume in shock (Meek). By central venous pressure studies, they differentiate peripheral vascular stagnation from central cardiac failure. Assuredly, their results merit careful reassessment of the entire question. Recently, some doubt has been cast on their basic premises. Meanwhile, from personal observation, the vasopressor drugs, metaraminol (aramine) and levarterenol (levophed) by slow intravenous infusion have been life-saving in isolated instances.

Physical measures have increasingly found expression not only in diagnostic but in therapeutic aspects of cardiology. Electrical shock (D.C.) is now widely employed in the conversion of arrhythmias. In the more dangerous atrial fibrillation and other potentially serious arrhythmias, cardioversion has an accepted place in treatment. Recently, electrical stimulation of

the carotid sinus nerve has been used to control angina. Defibrillators are an essential element of every resuscitation unit. In addition to electrical stimulation, free airway, mouth to mouth insufflation and closed chest cardiac massage (Kouwenhoven) are invoked in emergent states. Sodium bicarbonate is given intravenously. Isuprel has a prominent indication where chronotropic and not anotropic action is sought. Intracardiac epinephrine is deemed a ritualistic procedure by some; but, aside from its pharmacological action, mechanical stimulation by puncture of the myocardium may initiate independent contractions. Lidocaine should be given routinely in such emergencies. Again, teamwork and close coordination of the several efforts with a premium on time will assure the highest recovery rate.

Of the contributions of engineering to the medical effort, none is more impressive than the electronic pacemaker. This element, activated by a transistor implanted in the abdominal muscles, is connected to the heart by electrodes that are in turn imbedded in the myocardium. The impulses from the pacemaker take over the initiation of the cardiac contraction from the intrinsic neuromuscular apparatus of the heart and control the symptoms and signs arising from heart block (including the Adams-Stokes syndrome). One of the earliest and most efficient of these pacemakers was devised by Chardack and his associates (Veterans Administration Hospital, Buffalo, New York). To Central Office, Washington, there came an earnest appeal for help from the Czechoslovakian Embassy. Their Scientific Attache told of a physician in Prague who suffered from heart block with severe cardiac decompensation. This physician had learned of the development of the Chardack pacemaker and sought its support. By chance, one of the surgeons from the Oteen Veterans Administration Hospital was in Russia on another professional mission. Mechanically minded, he had taken a Chardack pacemaker with him. We related the fortuitous circumstance of its ready availability to the Czech representative. After due deliberation with his superiors, he asked that we initiate the request with the Soviet authorities for the movement of our surgeon to Prague. When we indicated the impropriety of such a procedure, the Czechs apparently went into another huddle. Eventually, after several weeks, the Czechs arranged for the movement of the American surgeon to Prague. Significantly, several Russian physicians accompanied him on his mission of mercy. Fortunately, for all concerned, the procedure was expeditiously performed and the results were highly successful.

Surgery has not lagged in capitalizing on the physiological and diagnostic advances in cardiology. The heart and great vessels were actually the last structures of the human body denied surgical intervention. Certain desultory approaches to intracardiac lesions had earlier been attempted (Cutler); but ligation of the patent ductus arteriosus was the first modern major surgical success (Gross and Hubbard, 1939).

I was busy with problems of military medicine in my office in Paris when Professor Crafoord was announced. He merely wished to pay his respects. My wandering thoughts were brought sharply to attention, however, when he said, "I have just completed my fourth successful correction of coarctation of the aorta." When I asked him to explain, he repeated his statement, giving the technical details of his procedure. Realizing Elliott Cutler's sustained interest in the field, I called him into my office to hear the wonderful message at first hand—a second major breakthrough in cardiovascular surgery. With remarkable technical support, open heart surgery replaced the blind closed technique. Sound approaches to complex problems can be planned on the basis of remarkably accurate diagnostic procedures. Acquired cardiac lesions joined congenital lesions as objects of surgical attack. Prostheses were early used in the replacement of damaged heart valves and diseased vessels. Natural tissue has had a priority; but synthetic materials have perforce had a wider utilization than might have been the choice. More recently homographs of the heart valves have been increasingly used. Endarterectomy, vascular grafting directly or bypassing, and various efforts to replenish the myocardial nutrition have largely been planned by the cineangiography of the compromised coronary circulation. At the present time, implantation of the internal mammary artery is widely employed for the last named indication (Vineberg). By affording extracorporeal circulation, mechanical pumps have played an important role in these great advances. At this time, transplantation of the human heart, while revolutionary and spectacular in the extreme, is still in the experimental stage. Further control measures and wider experience will establish its ultimate place in medicine.

At an earlier period the stethoscope was subjected to ridicule by such outstanding American litterateurs as Oliver Wendell Holmes and S. Weir Mitchell. An eminent radiologist, Merrill Sosman of the Peter Bent Brigham Hospital, Boston, made easy mirth of "this contraption," a

stethoscope prominently exhibited in the x-ray department (Figure 2).

The stethoscope was most disrespectfully treated on a later occasion. I had repeatedly stated that I could not walk, let alone think, without it. One morning a few years ago, *the* stethoscope was missing from my white coat pocket. Was some curious minded student putting me to the test? Or was there a conspiracy to put an end to the diabolic little tool with built-in murmurs, friction rubs and the like? After several weeks, employees were cleaning the elevator well, and there in the pit they found *the* priceless stethoscope.

The moral of the story is to keep your trusted ally close at hand. It is an instrument that will not wear out with use. Using it faithfully, you will develop a confidence that it will never betray. There are nuances and shadings that come only to the initiated. Rather distressing than flattering is the too common reaction of the patient, who says, "Doctor, this is the first complete examination I have ever had." In a period when the glamor of new objective methods, reinforced by gleaming, complicated apparatus, captures the imagination, do not forsake your God-given senses and the proven methods of our glorious past. Whatever the allure of the green pastures of the laboratory, remember—the most interesting object in the world is people. Preserve the vital patient-physician relationship at whatever cost. *The* stethoscope measures 20 inches (Figure 3) and I permit nothing to extend this distance between me and my patient.

Acknowledgment

My indebtedness to Dr. M. I. Smadel of the Lahey Clinic Foundation, Boston, for the reproduction of the Sosman exhibit, is gratefully acknowledged.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

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Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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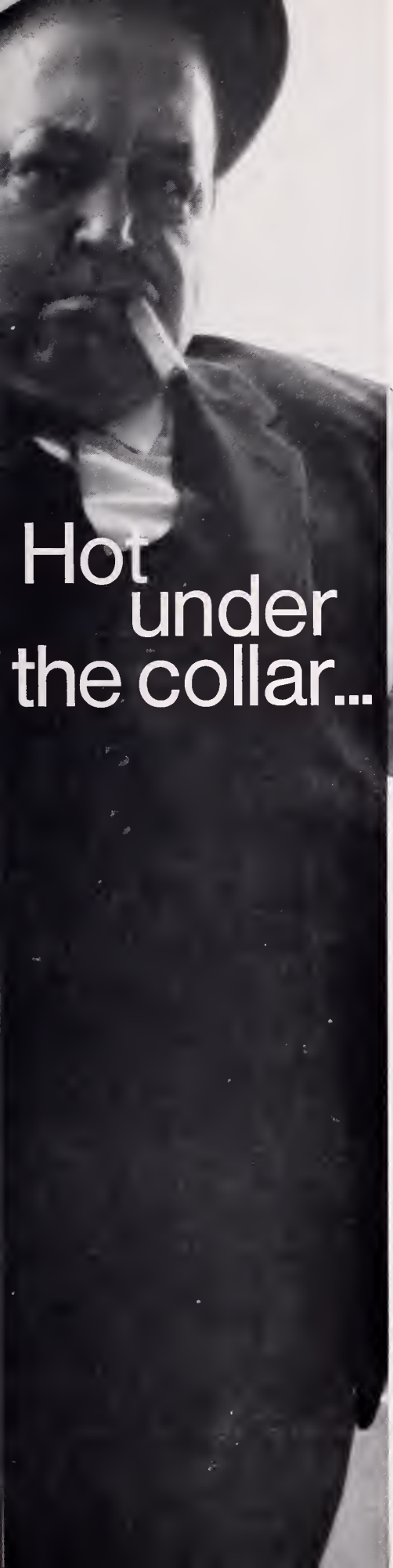

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Bell's Palsy in Pregnancy

Frederick W. Hanson, M. D., and Nicholas J. Teteris, M. D.

Two cases of facial palsy in pregnancy were diagnosed simultaneously at the Ohio State University Hospital and on the Obstetrical Service of the 840th USAF Hospital, Lockbourne A.F.B., Ohio. The infrequent occurrence of Bell's palsy in pregnancy prompted this review of recent obstetrical literature. Most of the standard textbooks of obstetrics do not mention this complication in association with pregnancy. Greenhill[1] does give brief mention of the disease in his textbook. Search of recent obstetrical literature reveals articles by Edwards,[2] Faris,[3] and Smith and Newton[4] which support the impression of relative infrequency of this condition.

Disease Mechanism

Bell's palsy or facial paralysis is an acute inflammation of the peripheral seventh nerve. According to Grinker and Sahs[5] it is a facial paralysis of acute onset due to nonsuppurative inflammation of the facial nerve within the facial canal. The edema accompanying the inflammatory changes leads to compression of the nerve fibers and finally to paralysis. Facial palsy can occur at any age. Young adults, particularly males, are more frequently affected. A definite etiologic agent has not been determined although viral infections have been most frequently suggested.[6] Predisposing factors such as exposure to cold, infection of the nasopharynx, and herpes zoster have been implicated.

Case Reports

Case 1, Figure 1.—H. G., a 19-year-old Negro female primigravida with an EDC of October 13, 1967, was admitted to the Ohio State University Hospital Obstetrical Service on September 17, 1967, complaining of numbness of the left side of the face of three days' duration. Shortly before the onset of numbness she had noted loss of taste in the anterior portion of the tongue. No history of recent illness, trauma, fever, exposure to cold, or respiratory infection could be elicited. Prior to this time the pregnancy had been uncomplicated except for obesity and mild preeclampsia which responded readily to diuretics and salt restriction.

Physical examination revealed a typical left facial nerve paresis. Treatment was symptomatic. It consisted of protection of the eye with a patch, and a five-day course of steroids. On October 2, 1967, she delivered a 2,320 Gm. infant without difficulty. The six-week postpartum examination revealed minimal residual of the facial paralysis. A screen on acute and convalescent sera for respiratory and encephalitis viruses demonstrated no rise in titers.

Case 2.—N. H., a 22-year-old white female primigravida with an EDC of August 28, 1967, was admitted to Lockbourne Air Force Base Hospital on September 14, 1967. Prenatal course had been complicated by elevation of systolic blood pressure late in pregnancy and an upper

Figure 1, Case 1. H. G., a 19-year-old primigravida at 36 weeks' gestation with typical left facial palsy.

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The Authors

- **Frederick W. Hanson, M. D., and Nicholas J. Teteris, M. D., Department of Obstetrics and Gynecology, Ohio, State University Hospitals, Columbus, Ohio.**

respiratory infection one week prior to admission. Laboratory studies on admission were within normal range. Initial therapy consisted of bed rest, phenobarbital, chlorothiazide, and a low salt diet. The blood pressure rapidly returned to normal. On waking the morning of September 17, 1967, the patient was noted to have a typical left sided Bell's palsy. Pitocin induction for moderately severe preeclampsia was unsuccessful on September 18, 1967. Blood pressure readings at this time were in the range of 160/100. Repeat laboratory data revealed a BUN of 30 mg. per cent; creatinine 1.2 mg. per cent and uric acid 11.2 mg. per cent. Successful induction with an uneventful delivery was accomplished on September 22, 1967. The postpartum course was complicated by a urinary tract infection which responded readily to Gantrisin. Postpartum medications consisted of Nicotinic acid, 150 mg. a day x 10 days and Prednisone 20 mg. a day x five days in divided dosages. Postpartum follow up at six weeks revealed a residual palsy estimated at five per cent.

Discussion

Reports in the literature and the cases reported here substantiate the opinion that Bell's palsy is coincidental and in no way improved or aggravated by pregnancy, labor, or delivery.[2,3,4] The reports of Edwards,[2] Smith and Newton,[4] and Faris[3] comprise a total of 19 cases. The age range reported is 17-40 years. Curiously, the disease is confined to the third trimester of pregnancy, particularly to the two weeks prior to delivery and the first two weeks of the puerperium. The incidence is not affected by gravidity, parity, or race. No particular antecedent pregnancy complications have been implicated; hypertension, however, has been noted in several cases.

Edwards[2] stated that there is no predilection for involvement of a particular side, reporting five left and four right sided palsies. Smith and Newton,[4] however, reported six left and one right; Faris,[3] three left. Both cases reported in this paper were left sided palsies.

Spontaneous total recovery was reported in approximately 80 per cent of cases with only two cases showing no improvement. Matthews[7] has reported only a 55 per cent recovery rate.

Symptomatology

The onset of symptoms is sudden with rapid progression to the fully developed clinical picture in 24-72 hours. The disease is characterized by unilateral or occasionally bilateral loss of motor control of the facial muscles with eversion of the eyelids, loss of forehead wrinkles on the affected side, tearing, loss of ability to frown and close the eyelid, and smoothing or disappearance of the nasolabial fold (see Figure 1). If the inflammation spreads to the chorda tympani there is loss of taste in the anterior two-thirds of the tongue. Pain may be present in the ear or the mastoid region. The treatment is conservative and symptomatic. It consists of heat, rest, analgesics as needed, protection of the eye with a patch, steroids to reduce inflammation, such as Prednisone 25 mg. per day x 7 days or Cortisone acetate 25 mg. t.i.d. x 3 days. The dosage schedule should not adversely influence pregnancy.

Electrostimulation and physical therapy can be employed for diagnosis and to prevent muscle atrophy in those cases that demonstrate slow recovery. The occurrence of toxemia preceding the clinical onset of the Bell's palsy in both of the cases reported may be coincidental, but one can not help but speculate that there may be some etiologic connection between the characteristic fluid retention of toxemia and the facial nerve compression within the facial canal.

Summary

Two cases of Bell's palsy in pregnancy are reported and the literature reviewed. Diagnosis, treatment and prognosis are discussed. The possibility that toxemia may be an associated etiologic factor during pregnancy is suggested.

The authors are indebted to Thomas M. Winn, Jr., Capt., USAF, M. C., 840th USAF Hospital, Lockbourne AFB, Ohio, for permission to report Case 2.

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Special Article

Your First Decade as a Doctor*

Robert Q. Marston, M. D.

STUDENTS of the graduating class, Dean Sleeth, Ladies and Gentlemen. I have chosen as my title today, "Your First Decade As A Doctor." Your first 10 years will be a period of critical importance to you. During this time you should expect much, and similarly, much will be expected of you. Sometimes we are clumsy in expressing what we want. This country is now expressing what it wants more forcibly, but perhaps less clearly, than it has for many, many years. It is expressing it in unusual ways in this election year; it is expressing it in the Poor People's March to Washington starting this weekend; it is expressing it in student protests in universities throughout the land; and it is expressing it in demands that the benefits of the miracles of medicine be extended to everybody. However unreasonable these demands may or may not be, they will not just go away. As a result, the opportunities for misunderstanding were never greater. These days we often start any new project with the expectation—indeed, with the conviction—that we will be misunderstood.

Two weeks ago, I met with the Secretary of Health, Education, and Welfare and the advance party for the Poor People's Campaign to hear a series of grievances and demands. What we heard was a reasonable presentation by sincere and concerned individuals—concerned not only for themselves, but, I believe, also concerned for the impact of poverty on all of us.

Despite their sincerity, there was an assumption at one stage that no one in HEW *wanted* to understand, or *could* understand, the delegation's message. To dramatize this assumption a Spanish-American man spoke to us entirely in Spanish, following which we were reminded, "You see, you couldn't understand a word he said." The point was well made, and it was valid for most of us. But what the visitors didn't know, and couldn't know, was that Secretary Cohen speaks and understands Spanish. When he replied, he did so in Spanish, assuring them that while he could not understand the previous speaker in full, he did have a partial understanding.

*Presented before the Seventh Annual Pre-Commencement Convocation of the West Virginia University School of Medicine in Morgantown on May 11, 1968.

The Author

- **Robert Q. Marston, M. D., Administrator, Health Services and Mental Health Administration, U. S. Department of Health, Education and Welfare, Washington, D. C.**

There is, of course, another aspect of our failure to understand each other. Often, it seems to me, the words "I don't understand," or "I don't know what you mean," actually mean "I disagree with you," or "I won't do what you want me to do." "No speak English" is a time-honored way to refuse to comply. When there is an attitude like this, a positive result is naturally impossible.

I want to talk to you today about clarifying our goals as a way of improving our understanding of each other. You are moving into your first decade as physicians, a decade that promises to be the most challenging and most exciting the health field has ever seen.

First, however, let me express my deep appreciation for the opportunity to be with you today. My association with the West Virginia University School of Medicine started on a very personal basis more than 20 years ago. About one-third of my fellow students during my junior and senior years in medical school had completed their first two years at West Virginia University. Later, when I moved into medical administration, I worked with Dr. Van Liere and others to ensure that West Virginia students coming to the Medical College of Virginia after the two-year course here would do so under no handicap. During the time that I was Assistant Dean in Charge of Student Affairs and Chairman of the Admissions Committee at the Medical College of Virginia, I always worked closely with students and faculty and the administration

of this institution, and I was involved in the phasing out of the program of cooperation and mutual understanding between the two states when it was no longer needed. Over all these years, I have enjoyed working with Dean Clark Sleeth and other members of your faculty.

This association with the West Virginia University School of Medicine has real pertinence to the main theme of my message to you today. I have watched this state mobilize its forces to provide health care for its citizens, beginning prior to the start of the present substantial Federal support program for medical education. This unusually strong emphasis illustrates the special role of health activities in our society; for health activities can be productive, not only in achieving better health for its own sake, but in providing a model for similar activities in other areas of social concern.

Throughout the ages health has been considered as much more than a means of satisfying individual desires for well-being and freedom from pain. It has been viewed as essential for the development of a meaningful society. Fortunately, for the most part health efforts have not been subjected to the whims of prejudice, politics or sectionalism as have so many other important endeavors. Yet today, both in this country and around the world, we still want more health than we have, and we are capable of attaining better health for our people than we have achieved in fact. This condition has always been true, of course. Hopes and expectations have never coincided with the real situation. But in recent years our awareness of this discrepancy has increased, and the forces, political and otherwise, that can do something to reduce the discrepancy are being recognized and mobilized. We are realizing in all aspects of medicine that an accommodation to these forces is not only necessary but may markedly increase our ability to achieve the goals we all set for ourselves when we first entered medical school.

But we have a problem with timing. I sense that decisions made last year and the year before, not just in government but throughout the Nation, in response to pressures for more and better health, may already have determined the way you will practice medicine in the early 70's. The decisions we make in the next few years will determine to a considerable extent the general nature of health care for the next decade or two.

We are faced with a problem not unlike that of the jet pilot. At any given moment he realizes that the attitude and direction of his plane was determined at a point several miles behind. In the new, fast-moving situation in medical affairs, decisions have already been made that will determine with an awesome inevitability where we will be at some point in time still well in our future.

It is therefore essential to focus more of our attention on what we are aiming for 10 or 15 years from now, rather than on the detailed problems of this year and next year. In addition to avoiding the immediate constraints in terms of manpower and financial resources—which handicap our ability to make short-term decisions—by looking at what we want 10 or 15 years from now, we may also be able to understand each other better here and now and benefit from the buffer of time.

No one in this room would question his individual duty to provide, to the best of his ability, the best health care for all for whom he has responsibility. This devotion to service has been typical of physicians throughout history. And yet the implications of this devotion for the individual are constantly changing. They were quite different as described by Sir Thomas Browne in *Religio Medici* in the 1600's, and by Sir William Osler at the turn of the present century. And they will be seen in a different light by this year's witnesses before Congressman Staggers of West Virginia, Chairman of the Interstate and Foreign Commerce Committee, as they testify in hearings on two important bills, the Health Services Amendments of 1968 and the Health Manpower Bill.

If I may interpret Sir Thomas Browne's writings, I think he was primarily concerned with the nature of man—a concern that the physician have a sound understanding of his fellow man from the very deepest philosophical base. He wanted the physician to blend the soul and the body by understanding himself better. Osler, two and a half centuries later, on the other hand, was determined that the physician should focus his full attention on the needs of the patient. This concern was exemplified by his introduction, among other things, of the clinical clerkship at Johns Hopkins. Indeed, the whole concept of his textbook, the "Principles and Practice of Medicine," was to emphasize general principles to be applied to the problems of individual patients, rather than follow the common pattern of the times, which was to apply the skills and pet theories that the individual physician possessed—almost regardless of the needs of the patient. We should remember, too, that Osler's conviction that the physician must see his patients *in the community* underlay his strong

dissent from the decision made at Hopkins to go to the system of a fulltime clinical faculty. That dissent contributed to his leaving America to become Regius Professor of Medicine at Oxford.

Moving into the present, Mr. Staggers and others in Congress this year face the need to identify the necessary and appropriate Federal actions to mobilize talent in medical research, to supply health manpower, and to organize and deliver health services, including all of the preventive, curative and restorative aspects of medicine, to those who need them. To do that, they will have to look closely at what the state of the Nation's health should be in the late 70's. They will have to look equally clearly at where we stand today. And along with all of us, they will have to chart a course to get there from here.

How shall we envision our state of health in the late 1970's? In terms of medical and scientific capability, the individual American man, woman or child could be very healthy indeed. He will be heir to the great scientific progress we have already achieved, plus the advances to be made in 10 additional years of accelerating research effort. He will be the heir also of sweeping social pressures which will have transformed good health from the status of a privilege for the fortunate to the status of a right which all can claim.

This hypothetical American of the year 1978 could have readily accessible to him, wherever he lives, a remarkable battery of preventive, curative and restorative services – capable of maintaining him in good health, detecting and diagnosing the onset of disease at an early stage, treating it efficiently, and restoring his strength and capacity for self-fulfillment. He also could be living in an environment that is not only free of unnecessary hazards to his health but also is positively conducive to productive living.

He *could* have these services in that kind of environment. Whether he *will* have them or not depends on decisions now being made. Congress will make some of them. Other governmental agencies and individuals will make others. So will the medical profession, the hospital profession, the universities and medical schools. Finally, very important participants in this decision-making will be the public—the people we seek to serve. Ultimately, health is their concern. We must, of necessity, talk about laws and authorities, politics and systems, plans and budgets; but at its root, health is a particularly personal province of individual human beings.

If we can agree on the nature of our health goal for 10 years hence, how shall the implementing decisions be made? Quite clearly we have a long distance to travel to change today's hopes into tomorrow's realities. We know that millions of our people are not being served as they might be served. We know that the costs of care are rising very rapidly. We know that we face shortages of basic resources—manpower and facilities—and that the demand for care will make these shortages even shorter. Meanwhile the pressures for action—for change—are building up throughout society. In seeking to accommodate to these pressures in a responsible and reasonable fashion, we must recognize that there are no evil dragons to be slain, no villians seeking to limit achievements in the health area. The problem is that we shall be trying to do something that has not yet been achieved, and for which no one has a blueprint. Basically, we will be trying to strengthen even further our present base of tremendous biomedical research accomplishments and then to make the fruits of our efforts and those of this country's unique medical education system available to all. And we must do this under conditions that will work best in our democratic society.

The social pressures for change, based upon the age-old desire to have the best health for all, plus acceptance of the relatively recent belief that health is a human right, have established beyond doubt a governmental responsibility to participate in the process of fulfilling that right. The question is no longer whether there is a Federal role in health, but how to define that role and how to use the Federal resources most effectively in partnership with other resources in the private segment of our society.

There are the problems that Congress is struggling with this year, and we can be sure that county governments and state governments will be increasingly concerned with them in the future. They are the problems that the President and all of us in the health components of the Federal establishment are grappling with. And they are the problems you and your fellow physicians will be helping to resolve in the next decade.

Some of the processes of definition have already been accomplished and some of the tools and mechanisms for interplay of Federal and non-Federal resources are already at hand. Passage of the Social Security Amendments of 1965, which include the Medicare and Medicaid programs, provided mechanisms for Federal participation in the payment of medical costs. Two

years before, the passage of the Health Professions Educational Assistance Act provided mechanisms for supporting increases in quality and quantity of health manpower. Mechanisms for supporting biomedical science and the development of medical facilities were already at work.

In all of these cases, the necessary and appropriate role has been defined in terms of support, of assistance, of stimulation of non-governmental effort. Medicare and Medicaid help to buy care that is already there. The other programs I mentioned give impetus and encouragement to local incentive—in conducting a research project, in building a hospital, in expanding a medical school.

This same principle is now being followed in the area where the pay-off should come—in developing systems and relationships to deliver care to the people who need it. The Regional Medical Programs, created by the Heart Disease, Cancer and Stroke Amendments of 1965, and the Partnership for Health Program, authorized by the Comprehensive Health Planning and Public Health Amendments of 1966, are both designed to start processes which will help make better care more readily accessible. Neither of these impose a Federal system. Both depend on and encourage initiative where it counts—out where the services are being delivered. On the non-government side, the American Medical Association, American Hospital Association, Association of American Medical Colleges, the voluntary health agencies, insurance companies, labor unions, and a number of citizen organizations are increasingly active.

We don't know whether any of these efforts will work. Let me repeat that this Nation is trying to do something that has never been done before—to create an environment in which a highly pluralistic system will develop cooperative patterns of many components working together so that each component will be able to do a better job of delivering health care.

I am convinced, and I speak as a citizen and not as a Federal administrator, that the Nation's powerful array of medical talent will rise to the challenge of change and will carry out its part of the overall responsibility, although in the process, I think, it will be seriously tested. The world of medicine you are entering as graduates is a world in process of accommodating to enormous changes. It presents an exciting scene. It offers more options for your talent and skill than any previous medical landscape in history.

For the last month, I have been looking with growing humility at one section of this landscape—that encompassed by the new Health Services and Mental Health Administration—with its array of activities and programs. Its responsibilities include those of direct health service to the Indians, the operation of Public Health Service hospitals, quarantine stations, and other direct activities in this Nation and internationally. It is concened with prevention of disease and the major problems of mental health, including research, training and the delivery of services. It has a major responsibility for maintenance of a national health statistics system. And it has a heavy investment in the so-called innovative programs—Partnership for Health and Regional Medical Programs. Most recently, it has established the National Center for Health Services Research and Development, so that we can have an appropriate balance between the development of new knowledge through research and its utilization.

This is a powerful array of authorities and mechanisms designed to assist a far more powerful array of forces, including the medical and other health professions, and ultimately to serve the whole 200 million people in our Nation.

I began by talking about opportunities for misunderstanding in this uncertain decade. This suggested that a clarification of goals was one way of approaching understanding; and this led to a description of some decisions being made by the Federal government that will affect health in the years ahead. By means of this somewhat wandering recitation, I hope you caught a sense of the sweep and scope we can expect in medicine in the years ahead; and I hope you caught a sense of the shared commitment to the goals of medicine—which are as old as civilization—projected against a society that is as contemporary as today's televised news via satellite.

I have been in government for a little over two years. Five or ten years from now, I may not be in government. I don't believe I think any differently in my present position than I did when I was treating patients, doing research, or teaching, or even than when I was a medical student. In all of these activities, and in my present one, the primary goal has been to improve the health of people.

Today attainment of that goal requires more than ever before that people in and out of the health field develop an increased understanding of shared commitment. If we can work together, we can accomplish all that is needed.

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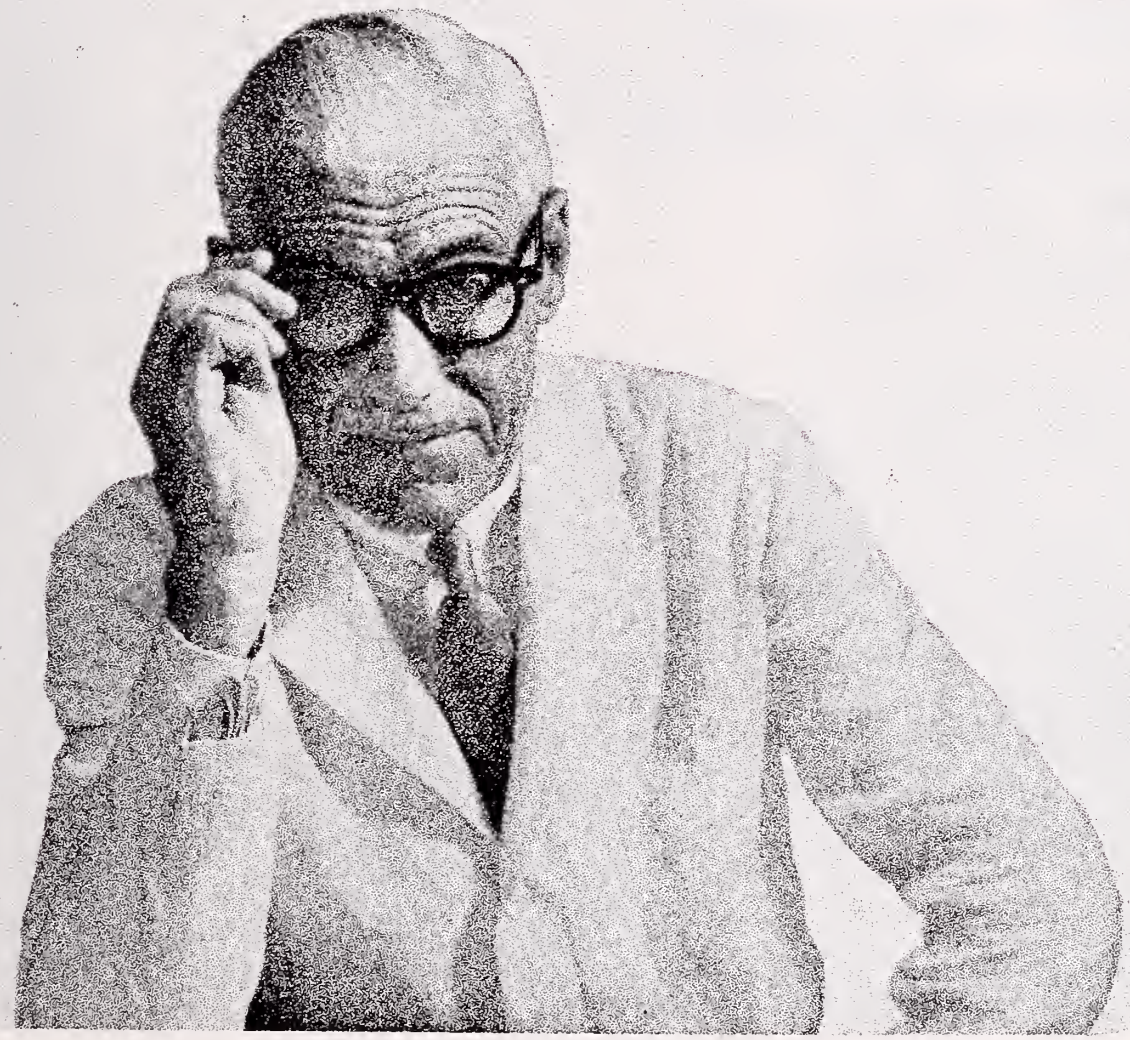

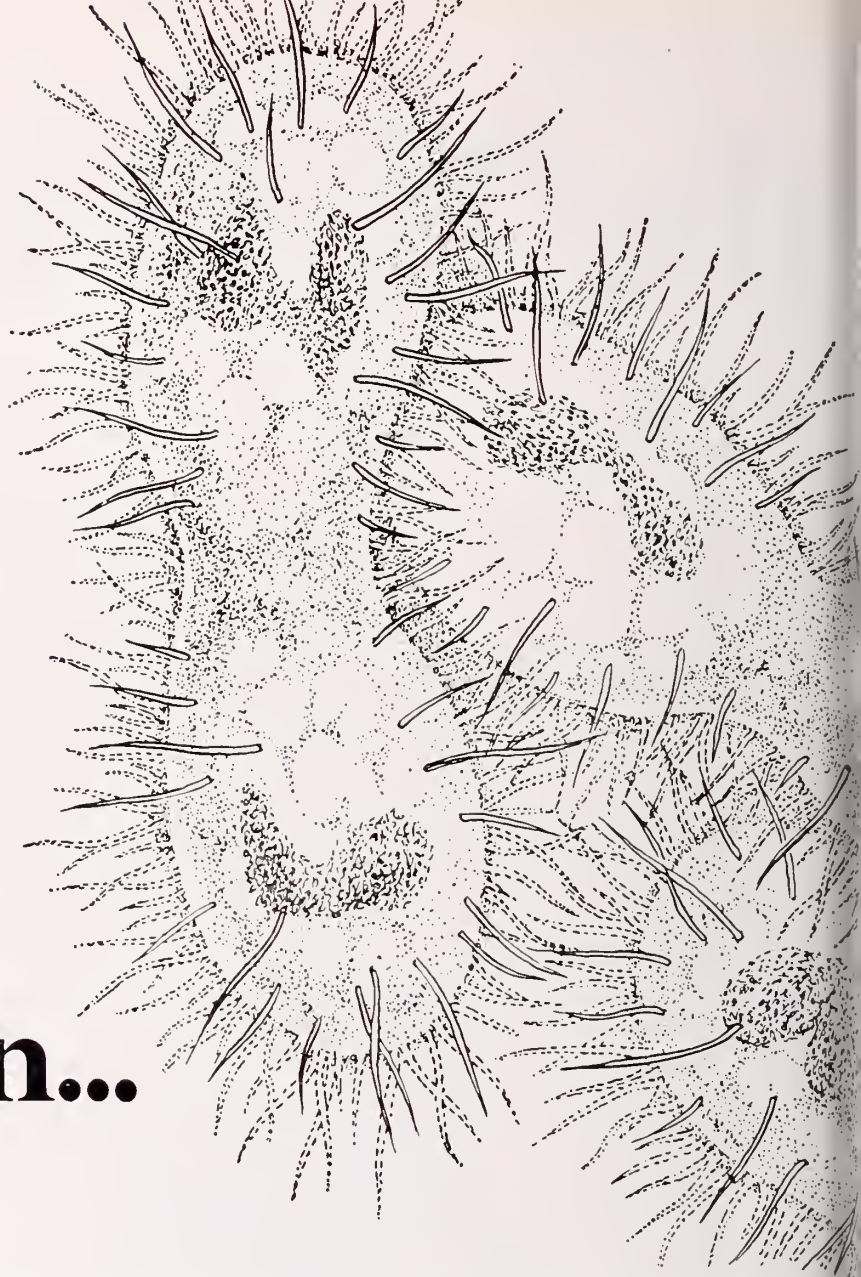

A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

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References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

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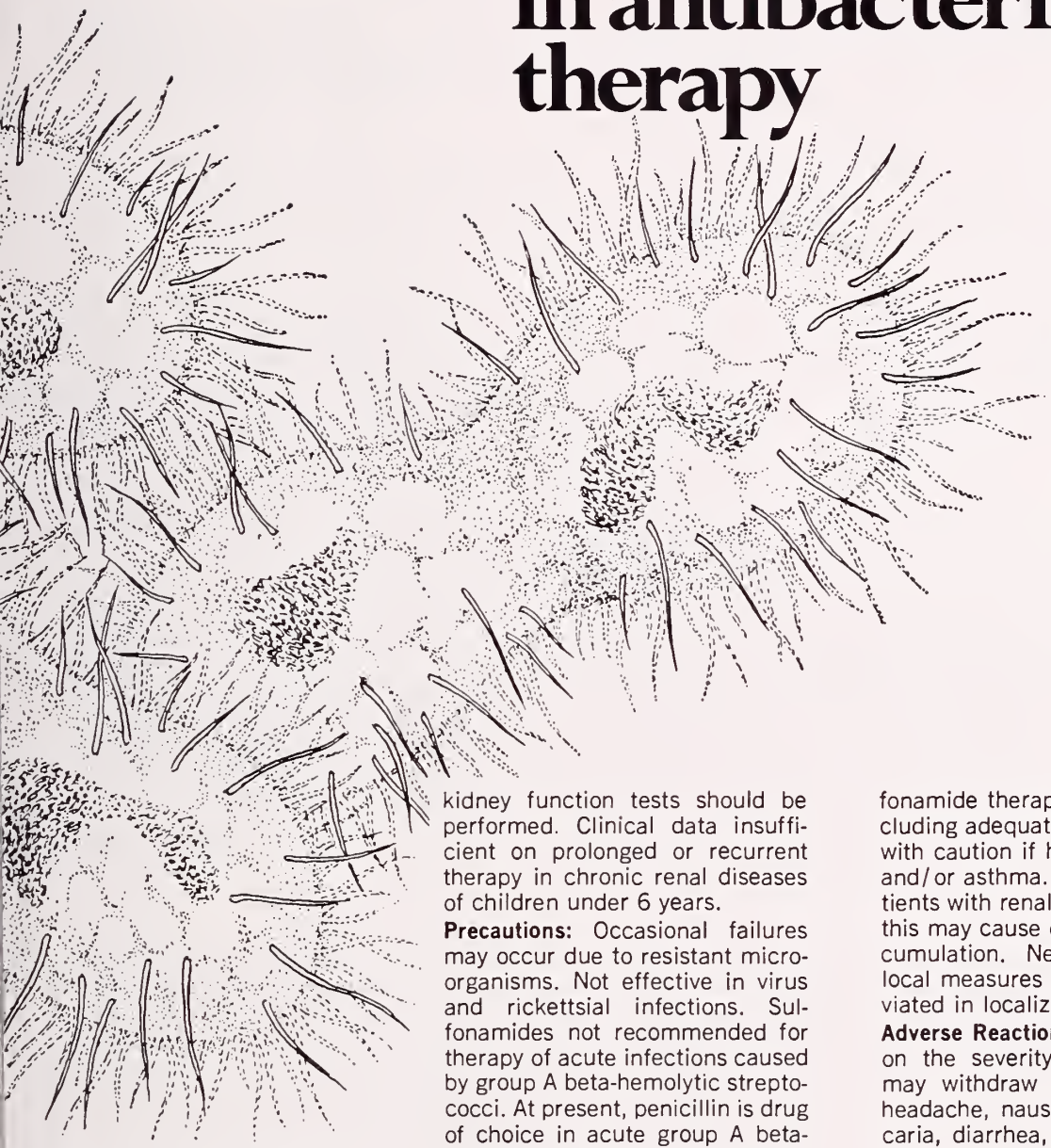

Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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Electrocardiogram of the Month

Digitalis-Induced A-V Nodal Tachycardia

Edward K. Chung, M. D.

Although digitalis is an indispensable drug in the treatment of heart failure and most supraventricular tachyarrhythmias, it may cause or aggravate the heart failure or various arrhythmias when digitalis intoxication develops.

The purpose of this paper is to review the previous literature concerning digitalis intoxication, with particular emphasis placed on the importance of early recognition of digitalis-induced arrhythmias especially A-V nodal arrhythmias in the presence of atrial fibrillation.

The Author

- **Edward K. Chung, M. D., Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratories, West Virginia University Medical Center, Morgantown.**

He improved gradually after the intravenous infusion of potassium and his cardiac rhythm has returned to uncomplicated atrial fibrillation three days later.

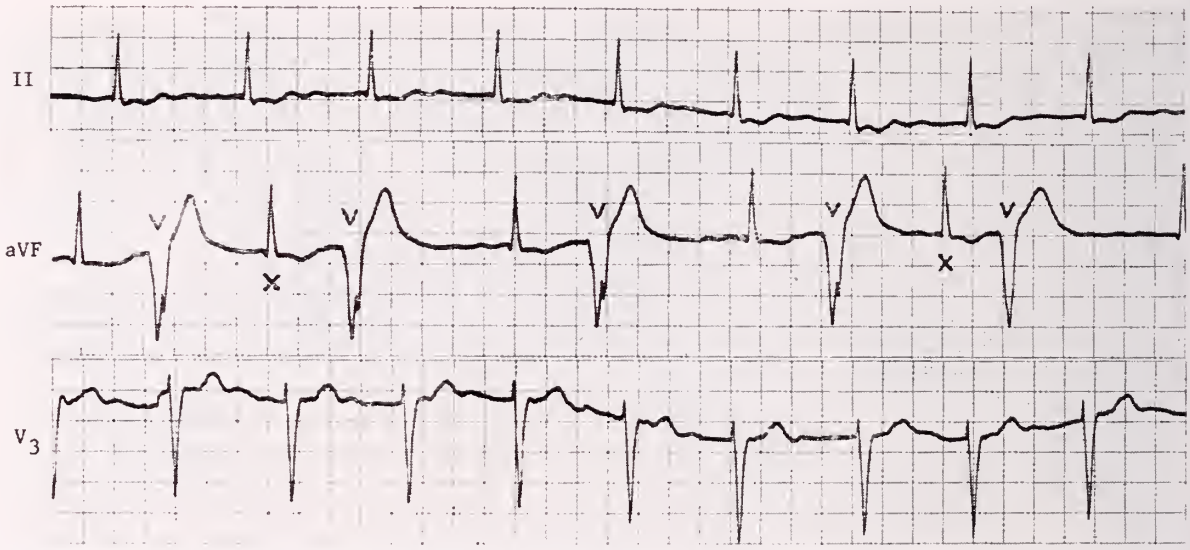

Figure 1: The rhythm is atrial fibrillation with predominantly A-V nodal tachycardia (rate: 73 per minute) producing incomplete A-V dissociation. There are frequent ventricular premature contractions (marked V) producing ventricular bigeminy. Note two A-V nodal escape beats in lead aVF (marked X).

Case History

A 70-year-old male who has been taking digoxin (Lanoxin) 0.25 mg. and Esidrix (hydrochlorothiazide) 50 mg. daily for congestive heart failure associated with chronic atrial fibrillation due to ischemic heart disease was admitted to the hospital because of increasing symptoms of heart failure.

Electrocardiogram taken on admission showed atrial fibrillation with predominantly A-V nodal tachycardia producing incomplete A-V dissociation and ventricular bigeminy (Figure 1). Digitalis intoxication was suspected and the drug was discontinued.

Comment

Although gastrointestinal symptoms such as anorexia, nausea and vomiting have been said to be the most common early symptoms, arrhythmias may often indicate digitalis toxicity without such signs. The occurrence of arrhythmias is particularly common and frequently the only sign of digitalis intoxication when using purified preparations.

Since the most serious and life threatening manifestations of digitalis intoxication are cardiac arrhythmias, the arrhythmias must be treated immediately. Otherwise, preexisting heart failure becomes rapidly worse under this circumstance.

It is a well known fact that digitalis may produce every known type of arrhythmia resulting from an alternation of impulse formation, and conduction. It is commonly observed that patients with digitalis intoxication demonstrate various combinations of arrhythmias. Arrhythmias may change from one to another in the same electrocardiographic tracing.

It is well documented that digitalis frequently induces various A-V nodal arrhythmia either due to passive impulse formation resulting in A-V nodal escape rhythm or enhancement of A-V nodal impulse formation resulting in A-V nodal tachycardia. The incidence of digitalis-induced A-V nodal arrhythmias has increased markedly in recent years probably because of a better understanding of the arrhythmia itself and a common association of atrial fibrillation as an underlying cardiac rhythm. This information is extremely important because this arrhythmia may be frequently misinterpreted as an uncomplicated atrial fibrillation or even sinus rhythm. In this circumstance, a continuous digitalization, needless to say, will lead to irreversible congestive heart failure with serious cardiac arrhythmias.

Summary

A recognition of digitalis-induced arrhythmias particularly A-V nodal arrhythmias in the presence of atrial fibrillation is extremely important because cardiac arrhythmias may often indicate digitalis intoxication without any other signs.

Sudden appearance of rapid or slow heart action during digitalization particularly in elderly patients should make one suspect digitalis toxicity rather than need for increased digitalis. Immediate recognition of digitalis toxicity especially digitalis-induced arrhythmias and withdrawal of digitalis are essential to minimize the relatively high mortality.

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4. Pick, A., Langendorf, R. and Katz, L. N.: A-V nodal tachycardia with block. Circulation 24:13, 1961.

To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual and immediate attention.

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Half the cars stolen last year had the keys left in the ignition. And more than half the car thieves were kids under 18. You don't have to be an "old pro" to steal a car . . . when the keys are in it.

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PLAN NOW TO ATTEND

A message from . . .

The President

ON THE AGENDA

In previous reports I have mentioned that I would discuss certain resolutions that were acted upon at the AMA Clinical Meeting last December.

One of the resolutions which I believe to be very important, is beginning to bear fruit. This resolution concerns Joint Accreditation of Hospitals. It is the recommendation of the AMA House of Delegates that each county and state medical society form a Committee on JCAH with the specific purpose of studying present and future requirements of the Joint Commission on Accreditation of Hospitals, evaluating hospital staff complaints and communicating regularly with AMA commissioners through the JCAH and making constructive suggestions for revision for improvement or revision of the standards. I also mentioned that the revised standards for hospital accreditation of the Joint Commission would be submitted to the state medical associations for review.

Each State has been invited to send representatives to a meeting with the AMA commisioners of the Joint Commission on Monday, February 10. Five copies of the revised standard, as provisionally adopted, were distributed to each state medical association for review purposes in January. It is my intention to appoint one or more members of the Association to attend the meeting and a report will then be passed on to the county medical societies.

Another important resolution was introduced by the Louisiana delegation and was passed by the House of Delegates after some changes by the reference committee. This has to do with "Health Care Under the Elementary and Secondary School Act." This should be noted by all county medical societies, and all school administrative bodies should be encouraged to consult with competent medical authorities prior to initiating and conducting programs involving any medical aspects funded under the Elementary and Secondary School Act. Local education agencies should be encouraged to consult with school health committees of their local medical societies as a means of accomplishing the above. The reason for this is that there has been a number of poorly conceived medical programs which have been started in some school systems because of lack of communication between the medical society and the school system.

Richard W. Corbitt MD,

Richard W. Corbitt, M. D., *President*

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EDITORIALS

MEDICAL TECHNOLOGY EDUCATION AT THE MEDICAL CENTER

It is unnecessary to dwell upon the indispensable role that medical technology plays in the field of clinical medicine. Suffice it to say that the significance of laboratory tests performed by well-trained and conscientious medical technologists cannot be over-emphasized. It is a truism to state that in many instances the physician cannot make his final diagnosis without critically reviewing certain laboratory test findings. It is, of course, extremely important that these tests be carefully done.

It is pertinent to remind the medical profession again[1] that the Medical Center offers a four-year course leading to a B.S. degree in Medical Technology. The curriculum was initiated in 1943. The first two years may be considered as pre-medical technology, and the last two years as actual medical technology. The first class of three students was graduated in 1947; the following year there were four graduates and the year following, five. This was indeed a humble beginning, but the enrollment gradually increased. Presently 29 senior students are enrolled. In point of fact, when the Medical Center was planned in 1951 it was designed to accommodate 25 entering students in medical technology. Presently there are more applicants than can be accepted. Residents of West Virginia are first considered, but in each class there is a sprinkling of out of state students. The majority of students are women. Since the curriculum was established, 235 students have been graduated.

The School of Medical Technology is, of course, fully accredited by the Council on Medical Education of the American Medical Association. It is most gratifying that several institutions which recently inaugurated programs in medical technology have based their curriculum largely on that presently in use at West Virginia University.

There is a constant demand for graduates in medical technology and actually the demands greatly exceed the supply. Fortunately, salaries now paid are more commensurate with the training these medical technologists have received than has been true in the past, but there still is room for improvement. It is significant that many women medical technologists, even after marriage and family responsibilities, often continue their work in clinics and hospitals.

Medical technologists, like physicians, are on 24-hour call. Their sound educational background, their scientific and technical training, their experience with patients, and their sympathetic understanding of people who are ill, all deserve respectful recognition by the medical profession. While it is hardly necessary to justify the establishment and development of the Medical Center of West Virginia University, it is worthwhile to emphasize that the training of

medical technologists is but another example of how a Medical Center can be of distinct service, not only to the individual physician, but indirectly to the citizens of the State.

1. Editorial. Medical Technologists. W. Va. Med. J., 52:313 (Sept.), 1956.

FRESH THINKING IN MEDICAL EDUCATION

The Commonwealth Fund on December 10 announced a $750,000 grant to Dartmouth Medical School to establish an educational program of medical studies required for the M. D. degree. The school will commence operation this Fall.

The school will enroll 53 students in a new medical curriculum which will shorten the time after high school to complete medical studies from eight to six years. Pre-medical education and medical school programs have each been reduced by one year. The internship will be an integral part of the medical school's education program and will concentrate on providing students, before they specialize, with the essential capacities of a general physician.

All medical students will be trained as general physicians as basic preparation for later practice.

The Commonwealth Fund release further records two other innovations. First, the Department of Psychiatry will participate throughout the four years of medical school and internship and second, the medical school plans extensive ties with hospitals around Hanover to enrich the experience of medical students and interns and to help the region's physicians to improve the quality of community medical practice. This is the third grant of the Commonwealth Fund to Dartmouth Medical School.

This is the first real attempt on the part of medical education to come to grips with the greatest need of medical practice, i.e., the shortage of family physicians. Nowhere in the U. S. is this need more apparent than in West Virginia. The diminution in the span of medical education from eight to six years, the integrated internship which will keep the graduate at his home base until he is eligible to practice, might be a helpful experiment in West Virginia. To date, the West Virginia University Medical Center has exported most of its graduates and so the school has given little assistance in relieving local physician shortage.

For years, the West Virginia State Medical Association has been providing scholarships for medical students. The recipients of such scholarships have signed a bond to enter into the private practice of medicine in rural West Virginia. At this date, one graduate has fulfilled the requirements of this scholarship. This must be the most expensive scholarship on record. Surely the time has arrived for all parties concerned to make another attempt to correlate physician shortage and physician education in West Virginia.

CAREERS OF WOMEN PHYSICIANS

Recently an article by Shapiro et al appeared in *The Journal of Medical Education*[1] concerning women physicians. The careers of women physicians who had been graduated from seven medical schools—four located in the state of New York and three in Pennsylvania—between the years 1945-1951 were examined. Questionnaires were sent to 319 graduates, and 269 (87 per cent) replies were received. Of this group, 91 per cent were currently in active practice; 77 per cent had been married, and 64 per cent had children. Women without children, almost without exception, were working full time. The majority of those who had a family were also working, but at a reduced level of activity.

Thirty-five of the women were board certified, and 195 were engaged in a specialty. The preferred fields were: pediatrics, internal medicine, psychiatry and anesthesiology; a fair percentage was also engaged in pathology, radiology, obstetrics and gynecology, and in preventive medicine and public health. Thirty-four were in general practice.

It is of interest that Van Liere and Dodds[2] in 1959 reported on the careers of 64 women who had taken their first two years of work at the School of Medicine of West Virginia University and had completed their clinical years elsewhere. Of these 64 graduates 45 had married, and had 22 children. So far as could be determined 28 were in general practice. The remainder were engaged in some specialty; the preferred fields were: obstetrics and gynecology, anesthesiology and pediatrics. Other specialties mentioned were: neuropsychiatry, internal medicine, ophthalmology, radiology and public health.

In this brief essay there is no particular point in making a detailed comparison between the studies of Van Liere and Dodds and those of Shapiro et al, except perhaps to mention that apparently women physicians in choosing their type of practice, like men physicians, make manifold choices. Van Liere and Dodds concluded from their studies that women make a

definite and useful contribution to the practice of medicine. Shapiro et al came to about the same conclusion, namely that their findings support the desirability of encouraging women to enter medicine and of facilitating professional activity by women physicians.

1. Shapiro, C. S. et al. J. Med. Education, 43:1033, 1968.
2. Van Liere, E. J. and G. S. Dodds, J. Med. Education, 34:911, 1959.

A NEW FEATURE— 'EKG OF THE MONTH'

With this issue, *The Journal* begins a monthly feature called "Electrocardiogram of the Month." This presentation is designed to offer at monthly intervals (we hope) an unusual electrocardiogram tracing which, with its interpretation, will be enlightening to those of us who encounter similar problems in our routine practice. The tracings are not designed to "stump the experts," but to assist those internists, general practitioners, pediatricians and others who find a working knowledge of electrocardiograph is essential to their medical practice.

The Journal is indebted to Dr. Edward K. Chung, Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratories, West Virginia University Medical Center, for introducing this special study. Cardiologists throughout the State are invited to submit manuscripts of a similar character.

For years, the Editorial Board has been attempting to develop an interesting and well-written CPC as a regular department of *The Journal.* Now, Dr. L. Walter Fix of Martinsburg, President of the West Virginia Association of Pathologists, is interested in the project and plans to submit some case conferences for publication in the near future.

Hospitals and clinics are urged to send *The Journal* interesting case reports.

Several state monthly journals now publish x-ray reports at frequent intervals and these studies attract a lot of reader interest. Any suggestions or submissions from West Virginia radiologists will be cheerfully received by *The Journal.*

The Decline Of Privacy

Once it was all so simple. You went to a doctor in whom you had confidence. You closed the door and spoke privately. Your conversation was as sacred and protected as words said in the ear of a priest in a confessional booth.

But now, 30 per cent of all medical bills are paid by third parties — Health Insurance, Blue Shield, Social Security, Retirement Benefits, Labor Union Plans, Medicaid, the Veterans Administration, and so on and on. Well you can't blame the paymaster for asking what he's paying for. So the diagnosis has to go into the files of an insurance company, a government agency, or an employer. And though it may be stamped "confidential" that is likely to do no more than whet the curiosity of the clerk, adjuster, attorney, messenger, or claim investigator in the office which receives the report.

Then come the data processing experts. They convert your diagnosis into holes in a punch card. This spews forth a "print-out" converting the holes into numbers or words on a tape.

We live in a fearfully complex environment where everyone's safety may depend on some one else's health. You want to know if the driver of your kid's school bus has epilepsy. Fair enough? But the Board of Education won't know it unless some doctor tells them. Is the pilot of your jet plane free of coronary attacks? Does the driver of a fast moving passenger locomotive have vision keen enough to distinguish a rising moon from a yellow signal light?

What of the patient in your office? You say that you are discrete. You insist that when it comes to telling about one of your patients, mum's the word. Well, is it? The police are entitled to know if you treated a gun shot wound or a narcotic addict. The AMA gives you a conscionable way out. Canon No. 9 reads: "A physician may not reveal confidences entrusted to him . . . unless he is required to do so by law, or unless it becomes necessary to protect the welfare of the community." That last exemption leaves in the tissue of confidentiality a hole big enough to drive an Imperial through. What's necessary to protect the welfare of the community? Finding a contagious disease? A bullet wound? A homicidal maniac? An epileptic bus driver? Your patient's fiance's syphilis? A paranoiac who plans to plant a bomb? A man with sadistically deviated libidinous drives who has been named as a foster parent by a trusting social agency? Or a pyromaniac loose in a sleeping city?

Anyway, every American-born adult has a health record and a psychologic record in the files of the school system, the armed services, and any health insurance companies to whom he has ever applied for coverage. That doesn't leave many Americans with blank files, does it?

And waiting in the wings is a proposed national data bank. Here will be permanently stored the minutiae of everybody's medical life — details which can be swiftly dug out by modern retrieval and computing methods. And just around the corner is a brand new electronic eavesdropping device!

Privacy — that's a seven-letter word you can still find in the dictionary. But soon, you'll have to go to the dictionary to find it.—*The Journal of the Medical Society of New Jersey.*

GENERAL NEWS

AMA President Honor Guest At 102nd Annual Meeting

Dr. Gerald D. Dorman of New York City, President Elect of the American Medical Association, will be among the honor guests at the 102nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23.

Gerald D. Dorman, M. D.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, said Doctor Dorman has accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 20.

Doctor Dorman will be installed as President of the AMA during the Annual Meeting next July in New York City.

Doctor Dorman was born in Beirut, Lebanon, where his father, Dr. Harry Dorman, was Professor of Obstetrics and Dean of the School of Medicine at the American University of Beirut. He came to this country at the age of 17 and received a B. A. degree from Harvard in 1925.

He received his M. D. degree from Columbia University in 1929. After internship, Doctor Dorman was engaged in the practice of surgery until 1942, when he entered the Medical Corps of the U. S. Army as a field surgeon, serving with the Second Evacuation Hospital in Europe. He retired five years ago with the rank of Colonel in the U. S. Army Reserves.

Doctor Dorman is a Vice President and Medical Consultant for the New York Life Insurance Company. He was an AMA delegate from the Medical Society of the State of New York for six years until he was elected to the AMA Board of Trustees in 1960.

In 1966, he became Secretary-Treasurer of the AMA and Secretary of the Board of Trustees.

Doctor Dorman is a member of many professional, business and public service organizations. He is a Fellow of the American Geriatric Society and the Industrial Medical Association, a Diplomate of the Board of Preventive Medicine and Occupational Medicine, and Chairman of the Council of the World Medical Association.

Doctor Dorman was married to the former Georgia Foster White, who died in 1960, and they had two children and seven grandchildren. In March of 1962, he married the former Lois Ackerman.

Scientific Program Nearly Completed

Doctor Stark announced recently that the scientific program for the meeting has been completed with the exception of one speaker. Names of the prominent physicians and surgeons who have accepted invitations to appear as guest speakers will be announced in future issues of *The Journal.*

One of the features of the scientific program will be a Symposium on "Cardio-Respiratory Emergencies and Their Management" which will be held on Saturday morning, August 23. Dr. Herbert E. Warden, Professor of Surgery at the WVU School of Medicine and a member of the Program Committee, will serve as Moderator and the participants will include an internist, surgeon and anesthesiologist.

Serving with Doctor Stark on the Program Committee are Drs. A. B. Curry Ellison and Seigle W. Parks of Charleston, I. Ewen Taylor of Huntington and Herbert E. Warden of Morgantown.

Business Meetings Scheduled

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 20.

The first session of the House of Delegates will be held on Wednesday afternoon, and the final session on Saturday afternoon, August 23.

Heart Fund Grant Requests Due by April 1

The West Virginia Heart Association has announced an April 1 deadline for applications for research grants-in-aid from investigators in West Virginia working in the cardiovascular field.

Individual requests should not exceed $3,000. Grants are not restricted to any particular discipline, but the investigator must be qualified and have the facilities available to pursue his work.

The Heart Association awards the grants to scientists who need interim or supplementary support for ongoing projects or to those who wish to demonstrate by pilot experiments the value of a new project.

Applications and additional information may be obtained by writing to Mr. Richard J. Bates, Executive Director, West Virginia Heart Association, 211 35th Street, S.E., Charleston, West Virginia 25304.

ACP Lists February-March Postgraduate Courses

The American College of Physicians will sponsor six postgraduate medical education courses in different parts of the nation during February and March.

The February and March schedule is as follows:

February 19-22 "Advances in Infectious Disease and Immunology," at Baylor University College of Medicine in Houston, Texas.

March 3-6—"Physiological Concepts of Clinical Disease," at The University of Texas Southwestern Medical School in Dallas.

March 17-21—"Recent Advances in Cardiovascular Disease," at the Mount Sinai Medical Center in New York City.

March 24-28—"Modern Pathology for Internists," at University of Pittsburgh School of Medicine and Presbyterian University Hospital in Pittsburgh.

March 26-28—"Three Days of Gastroenterology," at Emory University School of Medicine in Atlanta, Georgia.

Tuition fees are $60 for each course for members of the ACP and $100 for those physicians who are not members. Additional information may be obtained by writing to: Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Masters Program in Audiology Offered at WVU

A curriculum leading to the Master of Science degree in Clinical Audiology will begin at West Virginia University during the fall term of the 1969-70 academic year.

The University Faculty Senate authorized the Speech Pathology and Audiology Program to institute the curriculum.

The new course of study will emphasize the clinical aspects of the diagnosis, treatment, and rehabilitation of the auditorily handicapped individual. The student will encounter a wide spectrum of auditory problems and will have contact with the medical disciplines involved in patient care. Members of the medical staff will participate in the instruction and training.

Dr. Glen P. McCormick, Coordinator of Speech Pathology and Audiology at WVU, expressed the hope that West Virginia physicians will encourage qualified students to consider speech pathology and audiology as a professional career.

Cancer Day In Charlottesville

A "Student Cancer Day" program will be conducted by the Continuing Education Program of the University of Virginia School of Medicine in Charlottesville on March 7.

Information may be obtained by writing to: Continuing Education Program, Dean's Office, University of Virginia Medical School, Charlottesville, Virginia 22901.

554 More Registered Nurses Needed in State

A report on the current supply and need for nurses in West Virginia, recently released by State Health Director N. H. Dyer, gives six recommendations for improving the state nursing situation.

The report, which was compiled by Frances M. McKenna, Educational Consultant and Executive Secretary of the State Board of Examiners for Registered Nurses, also shows West Virginia needs 554 more professional nurses (1966 figures) to meet the 1970 goal of 375 per 100,000 population. Using projected population figures for 1970 and the number of registered nurses licensed in 1966, West Virginia had 290 nurses per 100,000 population.

The six recommendations which were included in a recent issue of the "State of the State's Health," are as follows:

—Recruitment should be done on an organized basis and extended to all parts of the State; interested candidates should be guided in their selection of program and that every effort should be made to fill classes. Counselors in high school should be provided with information and encouraged to assist in recruiting for nursing.

—Nursing education should be supported. Thought should be given to replacing the associate degree program at Marshall University in Huntington with a four-year baccalaureate program, and starting new associate degree programs.

—The problem of migration out of the state should be given immediate attention and remedial measures should be taken. The problem could be alleviated with such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions.

—Interested and promising diploma and associate degree graduates should be encouraged and assisted to satisfy requirements for the baccalaureate degree. Sufficient faculty should be employed not only to work with this group and facilitate their progress, but also to visit population centers in the State on a regular basis to advise those engaged in part-time study, or interested in undertaking a program.

—The possibility of opening a graduate program in nursing at West Virginia University should be studied.

—The "image" of nursing should be enhanced in every way to attract students and staff to schools and health agencies in the state.

On January 1, new and revised hospital licensing regulations became effective, as reported in the Health Department's weekly newsletter, "State of the State's Health." The regulations, standards and rules are not intended to be punitive, but rather to provide hospitals with a compendium of minimum requirements. They were formulated not according to arbitrary rulings, but as a result of the study of actively operating hospitals with the assistance of the various bureaus and divisions of the State Department of Health and representatives of hospital and nursing associations with final approval by the Advisory Board to the Hospital Licensing Program and the State Board of Health.

Two State Physicians Named To AMA Councils

Two members of the West Virginia State Medical Association were appointed recently to positions on two important Councils of the American Medical Association.

Martha J. Coyner, M. D.

Mildred M. Bateman, M. D.

Dr. Mildred M. Bateman, State Mental Health Director, received an initial appointment to the AMA Council on Mental Health; and Dr. Martha J. Coyner of Harrisville was reappointed to the Council on Rural Health, on which she has served since 1966.

Doctor Bateman is a native of Cordele, Georgia, attended Johnson C. Smith University and received her M. D. degree from Woman's Medical College of Pennsylvania in 1946. She interned at Harlem Hospital in New York, served a residency at the Veterans Hospital in Topeka, Kansas, and did postgraduate work at Menninger School of Psychiatry.

A Diplomate of the American Board of Psychiatry and Neurology, Doctor Bateman has been State Mental Health Director since July of 1962. She is a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Coyner, who received her M. D. degree from the University of Pittsburgh School of Medicine in 1952, is engaged in general practice in Harrisville and is a Past President of West Virginia Chapter of the American Academy of General Practice.

She served an internship at Ohio Valley General Hospital in Wheeling.

A native of Buckhannon, Doctor Coyner is a member of the Parkersburg Acamedy of Medicine, the West Virginia State Medical Association and the American Medical Association. She chairs two committees of the State Medical Association—the Rural Health Committee and the Committee on Medical Scholarships.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Academy of Pediatrics Offers PG Course on Infection

A postgraduate course in pediatrics will be offered by the American Academy of Pediatrics at the University of Kentucky Medical Center in Lexington, March 26-28.

The course is entitled, "Some Neglected Aspects of Infection in Children."

There will be a registration fee of $5 plus tuition of $75 for Fellows or applicants of the Academy of Pediatrics, and $105 for other physicians.

Inquiries about the course should be directed to Dr. Gerald E. Hughes, Secretary for Educational Affairs, American Academy of Pediatrics, P. O. Box 1034, Evanston, Illinois 60204.

Doctor Millis To Head New Program

Directors of the National Fund for Medical Education have elected John S. Millis, Ph.D., Chancellor of Case Western Reserve University, as a Vice President.

Doctor Millis joined the National Fund on January 1 to conduct a series of in-depth studies of the financing of medical education as it relates to present and future health goals of the nation. The studies will also be concerned with the utilization of manpower and plant, identification of shortages and alternative means of overcoming them.

Doctor Millis will continue to serve as Chancellor of the University until his retirement next June 30 but will devote a substantial part of his time to the new project.

Symposium on Hypertension March 13-14

A symposium on "Adrenal, Renal and Renovascular Hypertension: Diagnosis and Management" will be presented in Rochester, Minnesota, March 13-14.

Sponsor of the symposium is the Council for High Blood Pressure Research of the American Heart Association. Cooperating agencies are the Minnesota Heart Association, The Mayo Clinic and The Mayo Foundation.

Registration fees will be $45 for Fellows or Members of any American Heart Association scientific council and $60 for nonmembers.

Additional information may be obtained by corresponding with Mrs. Lorraine Kreiner, American Heart Association, 44 East 23rd Street, New York City, New York 10010.

Course in Electroencephalography

A course entitled, "Current Problems in Electroencephalography: Advances Toward Their Solution," will be conducted in Houston, Texas, March 13-15.

Additional information may be obtained by writing to Dr. Peter Kellaway, Baylor University College of Medicine, Texas Medical Center, Houston, Texas 77025.

Cleveland Clinic Announces February-March Courses

Seven postgraduate medical courses have been arranged by The Cleveland Clinic Educational Foundation during February and March. The courses and dates are as follows:

February 5-6—"General Practice."

February 12-13—"Controversies in Angiography."

February 19-20—"New Developments in Plastic Surgery."

March 5-7—"Advances in Urology and Nephrology."

March 12-13—"Newer Concepts of Surgical Treatment of Colon and Rectal Disease."

March 19-20—"Medical Microbiology."

March 26-27—"Medical Progress and Its Relationship to Dentistry."

Additional information about any of these courses may be obtained by writing to: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Fairmont Physician Signs Up For Vietnam Tour

Another West Virginia physician is serving a voluntary 60-day tour under the Volunteer Physicians for Vietnam Program.

Dr. Reverdy Jones, Jr., a Fairmont internist, left on January 9 to participate in the program. He was assigned to one of 120 provincial hospitals.

Physicians who participate in the program receive transportation and $10 a day for living expenses, but they are paid no fees.

Doctor Jones and nine other doctors received a briefing in Chicago on January 10 before leaving for overseas. Prior to leaving Fairmont, he remarked that he expected to encounter some diseases not ordinarily seen in his practice in Fairmont.

Drug Manufacturers Publish Booklet for Consumers

"The Medicines Your Doctor Prescribes" is the title of a new eight-page letter-sized booklet published by the Pharmaceutical Manufacturers Association.

Intended for wide distribution among consumers of prescription drug products, the booklet discusses the relationship of the doctor, the pharmacist and the patient in prescription drug use. It points out that such drugs actually are "medical treatment in product form."

The publication offers a number of practical tips to insure the safe and effective use of prescription drugs, and suggests that consumers not only budget the cost of health as a literal "living" expense but also consider pre-payment insurance for prescription drugs.

Copies are available upon request to PMA, a nonprofit scientific and professional trade association representing the manufacturers of 95 per cent of the nation's prescription drug products.

Looking Back 10 Years...

The Committee on Medical Care for Industrial Workers, a subcommittee of the Committee on Medical Economics of the West Virginia State Medical Association, held its organizational meeting 10 years ago in Charleston. Pictured are: Dr. James S. Klumpp of Huntington, then Chairman of the Medical Economics Committee; Dr. E. H. Starcher, now of Ripley, who was Chairman of the Subcommittee; and Dr. George F. Evans of Clarksburg, who at the time was the President of the Association.

New Association Members

Dr. Renato Castro, Ridge Avenue, New Cumberland (Hancock). Doctor Castro, a native of the Philippines, received his M. D. degree in 1957 from Manila Central University. He interned at Weirton General Hospital and Wheeling Hospital, and served residencies at Ohio Valley General Hospital and Wheeling Hospital. His specialty is internal medicine.

* * * *

Dr. A. K. Chadha, 1100 Market Street, Parkersburg (Parkersburg Academy). Doctor Chadha, a native of Pakistan, received her M. D. degree in 1962 from the Government Medical College in India. She interned at V. J. Hospital in Amritsar, India, and served residencies in that country and at hospitals in Baltimore, Columbus and Washington, D. C. She is engaged in general practice.

* * * *

Dr. James M. Garvey, 3600 West Street, Weirton (Hancock). Doctor Garvey, a native of Olean, New York, was graduated from Harvard College and received his M. D. degree in 1955 from the University of Buffalo School of Medicine. He interned and served a residency at Parkland Hospital in Dallas, Texas. He served as a Lieutenant in the Medical Corps of the United States Navy and was previously located in Marysville, California. His specialty is general surgery.

* * * *

Dr. R. R. Perez, Man Appalachian Clinic, Man (Logan). Doctor Perez, a native of the Philippines, received his M. D. degree in 1955 from the University of Santo Tomas. He interned at St. Mary's Hospital in Lewiston, Maine, and served residencies at the University of Louisville Hospital and Milwaukee Children's Hospital. His specialty is pediatrics.

* * * *

Dr. Robert P. Pulliam, 120 Professional Park, Beckley (Raleigh). Doctor Pulliam, a native of Beckley, was graduated from Davidson College and received his M. D. degree in 1962 from Bowman Gray School of Medicine of Wake Forest College. He interned at the University of Washington Hospital and served a residency at Sloane Hospital for Women. He served for two years as a Lieutenant Commander in the Medical Corps of the United States Navy. His specialty is obstetrics and gynecology.

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Dr. J. A. Renedo, Ohio Valley General Hospital, Wheeling (Ohio). Doctor Renedo, a native of Spain, received his M. D. degree in 1958 from the University of Seville. He interned at Wheeling Hospital and served residencies at the Ohio Valley General Hospital and Tacoma General Hospital in Tacoma, Washington. He served with the Medical Corps of the United States Air Force, 1963-65, and was previously located at the Armed Forces Institute of Pathology in Washington, D. C. His specialty is pathology.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Feb. 9-10—AMA Cong. on Med. Ed., Chicago.
Feb. 18-22—Am. Col. of Radiology, Atlanta.
Feb. 26-March 2—Am. Col. of Cardiology, New York.

March 13-15—AMA-ABA Medicolegal Symp., Las Vegas.
March 15-19—Am. Acad. of Allergy, Bal Harbour, Fla.
March 21-22—AMA Rural Health Conf., Philadelphia.
March 28-29—AMA Cong. on Socio Economics of Health Care, Chicago.
March 31-April 2—Am. Assn. for Thoracic Surgery, San Francisco.

April 9-11—Maryland Medical, Baltimore.
April 10-11—W. Va. Chap., Am. Acad. of Ped., Princeton.
April 13-17—Am. Assn. of Neur. Surg., Cleveland.
April 16-19—W. Va. Chap., ACS, White Sulphur Spgs.
April 18-20—Am. Soc. of Int. Med., Chicago.
April 20-23—W. Va. Acad. of Oph.-Otol., White Sulphur Springs.
April 21-23—Am. Acad. of Ped., Boston.
April 21-25—ACP, Chicago.
April 21-26—Am. Acad, of Neurology, Washington.
April 25-27—W. Va. Chapter, AAGP, Wheeling.
April 28-May 1—Am. Col. of Ob. & Gyn., Bal Harbour, Florida.
April 30-May 1—Am. Ped. Soc., Atlantic City.

May 5-7—Am. Gyn. Soc., New Orleans.
May 5-9—Am. Psychiatric Assn., Miami Beach.
May 6-7—Assn. of Am. Phys., Atlantic City.
May 12-15—Am. Urological Assn., San Francisco.
May 12-16—Ohio Medical, Columbus.
May 24-26—Am. Thoracic Soc., Miami Beach.
May 26-28—Am. Oph. Soc., Hot Springs, Va.

June 2-6—Am. Col. of Allergists, Washington.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.

July 11-12—Rocky Mtn. Cancer Conference, Denver.
July 13-17—AMA, New York.

Aug. 18-20—Am. Hosp. Assn., Chicago.

Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 6-12—ACS, San Francisco.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 11-15—Am. Col. of Prev. Med., Detroit.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.

The West Virginia Medical Journal

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Diagnosis and Treatment of Chronic Headaches*

Arnold P. Friedman, M. D.

Headache is a symptom in a wide variety of illnesses and is one of the most frequent complaints which the physician encounters in his practice. It may be only a distressing symptom in an already recognized disease, in which case it requires no particular study. More often it is the patient's presenting complaint. Because not all recurrent headaches are of the migraine or tension types, they must be differentiated from the headaches caused by intracranial lesions and other types of recurrent functional headaches. The following discussion of diagnosis and differential diagnosis is divided into: (1) vascular headaches of the migraine type and (2) conditions simulating migraine.

The vascular headaches of the migraine type can be categorized as:

Vascular Headaches of Migraine Type

Classic migraine, in which the headache is periodic, recurrent, and familial, and in which personality factors play an important role in the pathogenesis. As a rule, there are definite prodromes, including contralateral neurologic manifestations (usually visual, but in some patients motor or sensory). The pain is unilateral, throbbing, and lasts four to six hours; in the later stages the pain often spreads to other cranial sites. Anorexia, nausea, and vomiting are concomitant features. This type of migraine occurs in approximately 10 per cent of headache cases.

Common migraine, in which the prodromal symptoms are vague; may include psychic disturbances, gastrointestinal manifestations, and changes in fluid balance; and may precede the actual attack of pain by a period ranging from several hours to a number of days. The headache lasts for many hours or even several days. The pain is steady, unilateral, aching, or throbbing. Associated signs and symptoms include nausea, vomiting, fatigue, chills, local or general edema, and diuresis; nasal manifestations may occur, so that the physician may ascribe the headache to involvement of nasal structures. This type of migraine often is encountered in clinical practice.

Cluster headache, a type of migraine in which the pain occurs in a series of closely spaced attacks; remissions of months or years may occur. Prodromes are uncommon. Onset of the pain usually is sudden, as a rule at night, and may wake the patient after an hour or two of sleep. Associated symptomatology includes conjuctival injection, tearing, and nasal stuffiness, occasionally ptosis and miosis and, sometimes, unilateral or bilateral sweating. The pain is of short duration, subsiding after 20 to 90 minutes. This type of migraine is most common in men in the 40 to 60-year-old group.

Hemiplegic and ophthalmoplegic migraine is a rare type which may occur in young adults. The pain is moderate, ipsilateral, and is accompanied by extraocular muscle palsies involving the third cranial nerve (internal and external ophthalmoplegia) and other oculomotor nerves. Often the paralysis becomes evident as the intensity of the headache diminishes, usually three to five days after onset of a persisting headache.

The Author

- **Arnold P. Friedman, M. D., Clinical Professor of Neurology, College of Physicians and Surgeons, Columbia University; and Physician-in-Charge, Headache Unit, Division of Neurology, Montefiore Hospital and Medical Center, New York City.**

*Presented before the 16th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice in Charleston, April 26-28, 1968.

The hemiplegic migraine complex is characterized by neurologic deficits, hemiparesis, or hemiplegia. The neurologic phenomena of both types may persist for some time after subsidence of the headache. The third cranial nerve may be permanently injured if the attacks of ophthalmoplegic migraine are frequent. Some of these patients may have an intracranial aneurysm of the main trunk of the internal carotid or of its junction with the posterior communicating artery.

Differential Diagnosis

Vascular malformations, especially angiomas (most often in the parieto-occipital region), may cause sudden, severe headache. Usually, recurrent headache is the first manifestation, is on the ipsilateral side, and often is confined to the area over the malformation. Convulsions, focal signs on the contralateral side outlasting the headache, and a cranial bruit are among the neurologic signs. In the late stages, the headache becomes constant, and may be associated with subarachnoid hemorrhage, blood in the CSF, and coma. Auscultation of the skull should therefore be a routine procedure in examining a migranoid patient.

Aneurysm of a cerebral artery, with pressure on the adjacent nerves, may cause sudden, severe, unilateral headache which recurs on the same site. The presence of persistent visual field defects, and of sudden or increasing paralysis of the third and other extraocular cranial nerves, all of which suggest dilatation of an aneurysm, help in establishing the diagnosis. In the later stages, the headache is violent, constant, and mainly nuchal. This headache, too, may be associated with subarachnoid hemorrhage, blood in the CSF, and coma.

Tumors of the occipital lobe can cause headache, vomiting, and homonymous visual hallucination. Careful examination of the visual fields usually will reveal the presence of a persistent defect in the early, headache-free periods which may increase in severity (Figure 1). Later, signs and symptoms of an intracranial space-occupying lesion inevitably appear.

Temporal arteritis, in which the head pain occurs in older persons. The headache may be unilateral, but other cranial arteries and systemic arteries also may be involved. The pain is intense, of a deep, aching quality, throbbing, persistent, and with a burning sensation (absent

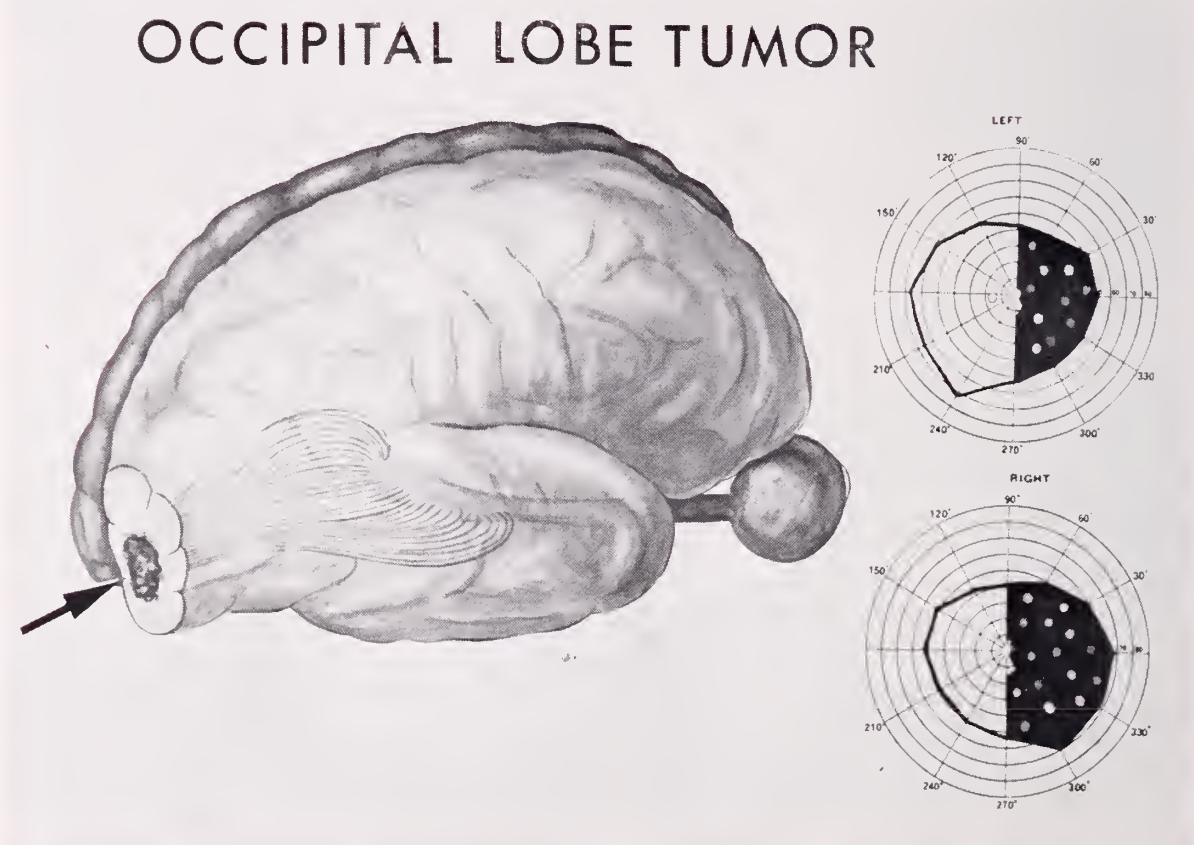


Figure 1

in most other vascular headaches). The throbbing usually diminishes or ceases after the early phase. During an acute attack, the superficial temporal arteries are intensely tender to touch, and may become thrombosed along part of their length. Pain on mastication, which may be the first symptom, is felt by many patients, but often the presenting complaint is of an ocular disturbance. Partial or complete loss of vision threatens more than 50 per cent of patients, so that early diagnosis and treatment are essential. Systemic signs and symptoms (fever, malaise, weakness, and CNS disturbances) may be part of the syndrome. The sedimentation rate is almost always elevated. Biopsy examination of the involved arterial segment establishes the diagnosis. Actually, the syndrome is a cranial arteritis rather than a temporal one, and the symptomatology varies according to the artery or arteries involved. Giant cell arteries has been found in biopsy samples of temporal arteritis, although palpation of the arteries failed to reveal the presence of arteritis.

Basilar and carotid artery insufficiency causes onset of headache late in life. It is accompanied by sensory and motor disturbances. Fairly often the pain is throbbing in nature, and probably is secondary to dilatation of the extracranial arteries; the increased flow thus provides collateral circulation.

Glaucoma, as a rule, causes extremely severe pain deep in the eye or, more often, in the brow or around the orbit; it may be associated with nausea and vomiting. The patient complains of failing vision for a short or long time and of variously colored halos around strong lights. The eye may be red and injected, and the cornea is hazy as a result of edema. Often, the pupil is fixed, semidilated, and oval. The presence of increased tension is revealed by pressing the eyeball. Funduscopy discloses glaucomatous cupping. Visual field defects may be found.

Epilepsy, which may simulate migraine attacks —by the similarity of visual, sensory, and motor phenomena that may occur in the prodromal phase of a seizure. Progress of the attack is rapid, unlike that of true migraine, and consciousness is nearly always impaired or lost. Some patients may suffer from both conditions; occasionally, severe attacks of migraine may end in an epileptic seizure.

In *Hypertension,* the headache often resembles migraine in its periodicity and unilateral localization, but nausea and vomiting are less common. Hypertensive patients, however, often have a history of many years of migraine. In severe hypertension, a pulsatile headache may occur on awaking and be associated with nausea and vomiting. Some relation between the intensity of the headache and the degree of hypertension is present in most of these patients. Decrease in blood pressure is followed by decrease in frequency and severity of the headache. In the case of a patient with hypertension, paroxysmal pulsatile headache, of severe intensity and short duration, and accompanied by perspiration, tachycardia, pallor, nausea, and vomiting, should arouse suspicion of pheochromocytoma. Pharmacologic and chemical tests, including urinary assays for catecholamines and their methoxy derivatives, will help to establish the diagnosis.

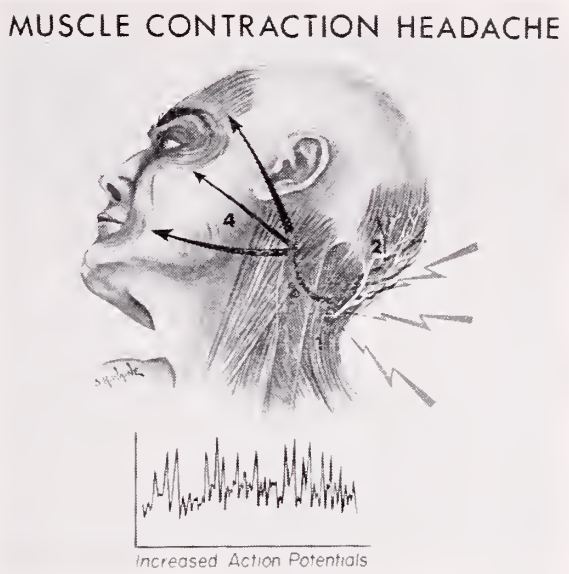


Figure 2

Muscle-contraction headache, (also known as tension, psychogenic, and nervous headache), unlike migraine, usually occurs concomitantly with a state of tension or anxiety. There are no prodromes, the headache usually is bilateral, occipital, or frontal, onset is gradual, and may be accompanied by various complaints, including anxiety and dizziness (Figure 2).

Anxiety and Depression States, and headache associated with Hypersensitivity and Allergic Reactions must be considered in the differential diagnosis of migraine. Although severe, throbbing headache seldom is a prominent symptom in acute anxiety states, headache is common in such states and may be associated with agitation, tremulousness, palpitation, nausea, and sweating.

A headache which persists for a long time (weeks to months) should not be readily accepted as migraine. The long duration suggests that underlying anxiety and depression are the

cause. Release of hostility often causes depression in the obsessional, migranoid patient. Such depressions must be differentiated from the more usual types of depression. A migraine headache, however, may occur during this period; this can be determined only by obtaining a careful and detailed history and by observing the patient.

Treatment

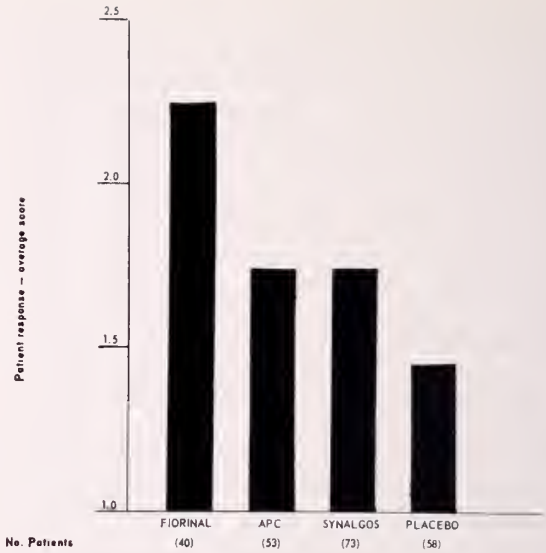
The single and most important factor in the treatment of migraine is that the whole patient, rather than the symptom, be treated. Next in importance is awareness that few conditions respond as unpredictably to treatment as migraine. Spontaneous remissions may occur for months or years, and may be followed by a varying period of greatly increased activity.

Symptomatic Treatment.—Various derivatives of ergotamine, combined with caffeine, antispasmodics, sedatives, and antiemetics, prove effective in treating the migraine attack. Caffeine acts synergistically with the ergot alkaloids; it also constricts the cerebral blood vessels, and thus reduces the blood flow, which may reduce the total dosage of ergotamine needed. We have found that the combination of ergotamine, caffeine, a sedative, and an antinauseant or an antispasmodic is most effective. Rectal administration is advisable, especially when vomiting prevents the oral route. Medication in adequate dosage must be administered early in the course of an attack.

In the late phase of a migraine attack, i.e., when muscle contraction and vascular mechanisms occur, an analgesic combined with a sedative is more effective than an analgesic alone (Figure 3).

Some patients who take ergotamine daily for many years become habituated to the drug. A number of our patients who have been taking two to three mg. daily for 15 to 20 years complain of daily headaches and some have had to increase the dosage to obtain relief. It has been suggested that such long-term use of the drug relieves the headache but alters the physiologic state of the blood vessels; this produces a rebound constrictive reaction, followed by dilatation and headache.

Ergotamine dependency accompanied by withdrawal manifestations is another possible complication of long-term, daily use of the drug usually in increasing dosage. Recognition of such patients is essential. The usual symptoms are increasing frequency of headaches, loss of the feeling of well-being, fatigue, let-down periods, and depression. Although the patient asserts that headache occurs if ergotamine is not taken, careful investigation reveals that use



Agents underscored by the same line are not significantly different from each other, viz., Fiorinal is significantly more effective than the other 3 agents ($p < .05$).

Figure 3

of the drug bears little relation to relief of the headache. The patient usually must be hospitalized for two to six weeks for a thorough study. Most of these patients wear the mask of migraine, but suffer from an underlying depression. Drug withdrawal and management of the depression constitute the basic treatment.

The presence of edema and electrolyte changes in patients with migraine, especially before the menses, has led to the use of diuretics in its treatment. Usually, drug-induced diuresis during a period of fluid retention or during a headache attack does not prevent or affect the headache. Occasionally, however, response to diuretics are worth a trial. Nevertheless, close correlation between retention of water and an attack of migraine headache has not been found.

Prophylactic Treatment.—Methysergide maleate (Sansert), a chemical relation of methylergonavine, was introduced as a prophylactic agent a decade ago.[1,2] Just how methysergide prevents the occurrence of migraine has not yet been fully elucidated. Many clinical trials have shown that the drug is effective in the prophylaxis of vascular headache, often reducing the number and severity of headaches, but it is ineffective during an attack. Our experience with methysergide covers over 1,500 patients with vascular headaches of the migraine type.

Adverse reactions occur in 12 to 20 per cent of cases. Adjustment of the dosage may control

such side-effects as nausea, cramps, vomiting, and restlessness. Occurrence of peripheral vascular effects, such as a vasospastic reaction simulating the Leriche syndrome, calls for immediate withdrawal of the drug. A syndrome resembling retroperitoneal fibrosis has been reported in a small number of cases with the patient on long-term methysergide therapy.[3]

In general, daily use of ergotamine for migraine prophylaxis is inadvisable. For patients with nocturnal attacks of headache (cluster headache), one to two mg. by mouth before retiring, for 10 to 14 days, may help to end the series of headaches. It may be combined with four mg. cyproheptadine HCl (Periactin), which may help to keep the daily ergotamine intake to a minimum.

Barbiturates, phenothiazine derivatives, the piperazines, and mild tranquilizers may be beneficial in migraine prophylaxis by reducing anxiety and temporarily improving the patient's ability to handle stressful situations. A combination of a belladonna alkaloid, a barbiturate, and ergotamine (Bellergal), also has been used for prophylaxis. Physical dependence on any of the drugs mentioned may develop, so that their usefulness is limited.

For patients with migraine who are subject to depression, the antidepressants are more effective than the anxiety-reducing drugs. The dibenzasepine derivatives, imipramine HCl (Tofranil) and amitriptyline HCl (Elavil), are the most effective antidepressants. Side effects are dryness of the mouth, palpitation, blurred vision, urinary retention, and, paradoxically, excessive sweating. Any patient taking these drugs, therefore, must be seen frequently, so that dosage can be properly adjusted.

Beneficial effects of hormone preparations in the prophylactic treatment of migraine have been reported over the past three decades. A synthetic progesterone recently has been reported to be effective in the prevention of migraine, but definite conclusions about its effectiveness await long-term controlled studies.[4]

Diphenylhydantoin (Dilantin) has been used intravenously for temporary interruption of attacks of cluster headache. The anticonvulsants have not prevented migraine headaches except in a small number of cases in which the patient's family history reveals aphasia and his EEG is abnormal, with spiked patterns. In some of these cases, the hydantoins may be combined with caffeine for more effective results.

Emotional factors apparently are the most frequent precipitants of migraine attacks; treatment of the psychologic problems is therefore of great importance. Psychotherapy, like all medical therapy, may range from supportive to long-term treatment. Therapy must be tailored to each patient, and will vary with his insight, resistance, and personality structure. Through it all, the patient-physician relationship determines the treatment. The opportunity to ventilate and discuss problems with an interested person reduces pressure and greatly relieves emotional tension. Modifying life goals and altering stress-producing situations by re-education, guidance, and environmental manipulation will allow the patient to readjust his life situations and change his responses to them.

Summary

The meaning of headache can be considered only in relation to the individual patient and his environment. Selection of suitable treatment depends on a correct diagnosis which, in turn, depends on a carefully taken and detailed history, and correct medical, neurologic, and psychologic assessment of the patient.

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Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.

Gastrocolic Fistula: The Only Manifestation Of a Benign Gastric Ulcer

Thomas O. Dotson, M. D., and Wihbi A. Shu'ayb, M. D.

GASTROCOLIC fistulae usually are caused by malignant tumors of the colon and stomach. Less frequent causes include chronic ulcerative colitis, lymphoma, regional enteritis, syphilis and tuberculosis. Gastrocolic fistula resulting from benign gastric ulcer rarely is reported.[1]

Verbrugge,[2] in 1925, reviewed the literature and found 25 cases of gastrocolic fistula caused by benign gastric ulcer. Of this number, only one had occurred since 1903. Smith and Clagget[3] reviewed the literature from 1903 to 1964. They found six reported cases and added one of their own. Deshpande[4] reported a case of a large, benign, gastric ulcer with concomitant gastrocolic and gastrojejunal fistula. Fontaine[5] *et al.* reported a case of gastrocolic fistula with two gastric ulcers and one duodenal ulcer. One of the gastric ulcers perforated into the colon.

The following case is reported because of its rarity and because of its unusual clinical manifestations.

Case Report

C. F., a 52-year-old white woman, was admitted to West Virginia University Hospital with the chief complaint of diarrhea for two years. Coincident with the onset of diarrhea, she complained of a "flu-like" syndrome characterized by anorexia, abdominal pain and myalgia. She experienced 20-25 watery stools per day containing undigested food and occurring after meals. Episodic abdominal cramps had been an additional symptom in the preceding six months. She had lost over 100 pounds during the previous two years even though she ate voraciously. Three months prior to admission she began vomiting copious amounts of sour, fetid liquid containing particles of food eaten the night before. Peripheral edema developed two weeks prior to admission. The patient denied having epigastric pain or other symptoms of peptic ulcer disease.

She had a convulsive disorder dating back to age 15, presently controlled with Dilantin and phenobarbital. In 1949, she had a bizarre illness that she could not adequately define, characterized by psychiatric withdrawal and flexion contracture of her hands. In 1934, a rectal fistula was excised. She smoked two packages of cigarettes per day. Menopause occurred in 1963.

Submitted to the Publication Committee, June 14, 1968.

The Authors

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Physical examination showed an emaciated, chronically ill, middle-aged, white woman with flexion contractures of her hands. Her weight was 95 pounds. Vital signs were normal. Positive findings were confined to the abdomen and extremities. The liver was 2 cm. below the right costal margin. There was no abdominal tenderness. There was 2+ pretibial pitting edema. Neurologic examination disclosed decreased sensation to pinprick, vibration and position in her hands and feet. The latter was considered by the consulting neurologist to represent a peripheral neuropathy from nutritional deficiency.

Laboratory values included hemoglobin of 11 Gm. per cent, hematocrit 34. Leukocyte count was 6,300 with a normal differential. Electrolytes were normal. Total protein was 6.1 Gm. per cent with A/G ratio of 3.5/2.6. Blood urea nitrogen and blood sugar determinations were normal. A three-day stool for fecal fat was collected and showed a total of 5.4 Gm. per day or 24.6 per cent of dry matter. Barium enema demonstrated a fistula between the greater curvature of the stomach and the splenic flexure. This was confirmed by a barium swallow.

Treatment

Following transfer to the surgical service, preoperative preparation included enemas, laxatives, antibiotics and a low residue diet. For one week she was given high doses of vitamins and intravenous supplements of protein hydrolysates and blood. An exploratory laparotomy was performed and the gastrocolic fistula found.

The proximal jejunum was adherent to the fistula, but it had no other connections. Resection of the fistula *en bloc* with vagotomy, hemigastrectomy and partial colectomy was performed. A Billroth I gastroduodenostomy was then done. The pathological report was gastrocolic fistula compatible with penetrating chronic peptic ulcer.

Postoperatively, the patient did very well and was discharged two weeks after surgery. She was symptom free and gaining weight. She was followed in the clinic and gained 20 pounds in one month.

Comment

The case just described was of interest in that gastrocolic fistula was the first and only presenting evidence of ulcer disease. Unlike other reported cases,[3, 4, 5, 6] the patient had no acid eructations, epigastric pain, or melena.

The diarrhea, weight loss and foul-smelling eructations were typical manifestations of a gastrocolic fistula. The diagnosis was established by a barium enema and barium swallow. The latter was of additional help since only 27 per cent of cases are shown by barium swallow compared with 95 per cent[7] demonstrated by barium enema.

Although a two-stage procedure as advised by Pfeifer and Kent[8] was considered, a one-stage procedure was done after adequate preparation. This has been done more frequently since 1940, with a comparatively low mortality because of better understanding of the pathophysiology of the disease and improvement in the preoperative care. Bowel preparation, correction of anemia and fluid and electrolyte disturbances, and progress in antibiotic therapy have made the procedure feasible. Correction of the ulcer diathesis by vagotomy and partial gastrectomy is important to prevent recurrence of the disease as suggested by Lahey,[9] in 1935.

Summary

A case of gastrocolic fistula secondary to benign gastric ulcer is presented. The patient had no other symptoms of ulcer disease. Ten similar cases have been reported in this century. A one-stage procedure consisting of *en bloc* resection of the fistula, with partial gastrectomy, partial colectomy and vagotomy was done. The symptoms of diarrhea, weight loss and foul-smelling eructations disappeared after surgery.

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Vaginal Prolapse and Stress Urinary Incontinence*

Robert A. Ross, M. D., and Hugh M. Shingleton, M. D.

THE anatomic structures of the female pelvic diaphragm have remained constant, but the symptoms ascribed to their weakness, altered position, separation and histology have changed. Explanation of stress urinary incontinence has been studied and considerable relief of this bothersome symptom has been the result, but the simple act of micturition, like thirst, has not been explained.

The Authors

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Patient Care and Professional Enlightenment

Prophylaxis, closer attention to the birth process, recourse to the procedure of episiotomy, more careful post-delivery checking, increased incidence of hysterotomy, pre and post partum exercises, all account for some decrease in pelvic relaxation. A more enlightened interpretation of such subjective complaints as backache, pelvic congestion, heaviness, bearing down sensation and menstrual irregularities has eliminated some of the emphasis on the presence of tissue weakness as the chief cause of such complaints. No doubt the more widespread and revised employment of the definitive operation of vaginal hysterectomy often has incidentally corrected muscle and fascia weakness. The same benefit applies to the increased use of estrogens during the climacterium.

Cystoscopy, fluoroscopy, opaque studies, sequential films and chain cystoroentgenography have more accurately explained and located the anatomic basis of classic stress urinary incontinence.

Kelly and his contributions typify the era of the meticulous anatomic gynecologist. The careful dissections and recordings of Curtis aided in eliminating imagined supports and emphasized the more dependable. The dextrous Joseph Price demonstrated the comparative safety of the vaginal approach in the operative management of female pelvic disorders.

The solid background information of these scrupulous teachers and clinicians has lessened the use of mechanical supports, improvised expedients and temporary measures. This fundamental information is available to the resident in training and offers a logical base of departure for innovations, improvement and the fascinating operative opportunity to utilize available tissue for diverse application and cultivates what should be the healthy talent of improvising, hopefully with an indwelling sense of restraint.

In reviewing the myriad procedures devised and recorded, the suggestion is inescapable that all are generally adequate, that none is greatly superior and that all fall short in some particular. The last is not entirely true. There is a place in the operative armamentarium for such procedures as trachelorrhaphy, the Manchester operation, anterior and posterior vaginal repair and the forgotten cautery. After careful, well documented study and adequate preparation, no apology is necessary for their employment.

We have used the vaginal approach in attempting to correct vaginal relaxation, prolapse of the vaginal wall and pelvic viscera. On rare occasions, the transabdominal approach has been recorded. Our results are similar to those generally reported.

Stress Urinary Incontinence. — An excellent example of the ability to utilize tissue and improvise by those possessing anatomic and physiologic knowledge is illustrated by Burch's necessity in utilizing Cooper's ligament as a point of fixation for sutures in correcting stress urinary incontinence during an operation in 1958. The method is now his procedure of choice and he reports the results in 143 cases in which the operation was performed[1] with remarkably good results. Six cases, 4.2 per cent, were complete failures and four cases, 2.8 per cent, were partial failures in relief of stress incontinence. The resultant complication that caused Buch most concern was the development of an enterocele (4.8 per cent). This is somewhat difficult to explain.

*Presented by Doctor Ross before the West Virginia Obstetrical and Gynecological Society during the 101st Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-24, 1968.

Everett, in discussing this presentation, remarks on the unusually high percentage of relief and states his belief that in most of the cases, this was a primary procedure. Only 12 of the 143 patients had had previous surgery for stress incontinence.

Wharton and Telinde[2] reported on their personal use of the fascial sling technique. Of the 82 patients, only 19 had not had a previous operation. The percentage of good results was 75.

During the first decade of the operation of our hospital, the operative management of female stress urinary incontinence was relatively uniform. If there had been no previous vaginal surgery, anterior colporrhaphy, with or without vaginal hysterectomy, was performed. An effort to follow the Kelly technique was stressed; if an abdominal incision was indicated, the Marshall-Marchetti[3] type of vesico-urethral suspension was included. When a previous operation for stress incontinence had failed, a vesico-urethral suspension was done, with or without associated colporrhaphy.[4]

The charts of the 60 patients treated during this 10-year period were reviewed by a fourth year medical student as a basis for his thesis. He recorded the simple statement that the 34 patients had said that they were completely satisfied with the result of the operation.

Green,[5] using chain cystogram, described two major types of bladder defect in these patients and chose surgical treatment according to bladder configuration. The Type I bladder has a loss of the posterior urethrovesical angle. Type II has a loss of this angle and has rotation of the urethral axis beyond 45 degrees on lateral standing-straining exposure. Green reported good results by performing anterior colporrhaphy in patients with the Type I bladder. If abdominal procedure was indicated, a vesico-urethral suspension was performed. In the Type II bladder cases, anterior colporrhaphy and suprapubic vesico-urethral suspension were combined. He reported a 90 per cent cure rate on a two-year follow-up.

Chain Cystogram Technique

Since 1962, we have employed the chain cystogram technique in our diagnostic studies[6] following cystoscopy, intravenous pyelography and cystometrogram. Urine cultures were performed previously. In the event of findings other than true stress incontinence, the patient was treated differently. True cystocele is easily differentiated by the chain technique. All of our patients who complained of stress urinary incontinence had abnormal chain cystograms. Patients with cystitis, trigonitis or polyps of the bladder ordinarily have normal chain cystograms.

In our series, reported in 1962, only those patients who received adequate follow-up for over one year were reported. There were 49 such patients. The average age was 42.5 years and the parity range was 1 to 12. Our results following Green's criteria were 75 and 82 per cent cures in Types I and II respectively, and improvement of 23 per cent over our previous single attempts in a group of 36 patients whom we were able to follow.

The patients had postoperative chain cystograms at approximately one week. This procedure has been quite helpful in predicting the ultimate results of operation.

Pereyra,[7] in 1969, published his innovation designated as "a simplified surgical procedure for the correction of stress incontinence in women." Later he and Lebherz[8] reported their combined results in the treatment of 210 patients with a cure rate percentage of 94.3 observed at 12 to 24 months, and a rate of 91.9 at 12 to 89 months' follow-up period. This unusually high cure rate is likely the result of selectivity of patients, evaluation of tissue dependability, complete urologic study and the dexterity of two individuals doing repetitive procedures.

Pereyra's Instrument and Technique

For the past three years, we have on occasion utilized Pereyra's instrument in this and an affiliated hospital and have followed his recommended technique. There have been 65 patients operated upon, 41 on whom a complete follow-up evaluation was possible. This series represents approximately 12 house staff and four attending who have performed the operations. The rate of completely satisfactory results on those followed adequately was 65 per cent. Our failures were evident within one year.

Paradoxically, we have encountered stress incontinence developing after a vaginal operation for the relief of vaginal prolapse, colpocleisis in three instances, where there was none previously. We have also observed relief of stress incontinence in progressive prolapse and once after acute retroversion of an enlarged uterus.

Our total experience in attempting to relieve the primary complaint of stress urinary incontinence by operative methods embraces 174 patients; satisfactory follow-up of 12 months was possible in only 75 per cent. The percentage of patients in this follow-up who had complete relief was 63.

The percentage of the total number of patients who had had previous operations directed toward relief of this symptom was 12, and that of those having some other pelvic or vaginal operation previously was 24. There were nine senior attending staff and 48 members of the resident staff who performed one or more types of operation primarily for the relief of stress incontinence. The obligation of house staff training is evident in our results. The main supervision has been directed toward proper selection of patients with true stress incontinence.

We will continue to follow the preliminary study as outlined, utilize the chain cystogram and employ vaginal surgery, urethrovesical fixation, one or both, and probably limit the use of the Pereyra procedure. We will continue to evaluate the possible relief at one year postoperative follow-up.

Summary

In reviewing the results achieved by many operators, employing many and varied procedures in an effort to correct the distressing symptom of stress urinary incontinence in the female, chance of success follows careful selection, scrupulous study and the competence and experience of the operator. In such circumstances, favorable outcomes should approximate 85 to 90 per cent.

Preternatural dexterity and occasionally preternatural judgment are found in the doctor in training, but there are those who are inept. It is the responsibility of the teacher to accentuate existing capability and gently direct a safe and effective course for those with limitations.

The same basic knowledge of anatomy and physiology and acquaintanceship with applicable procedures likewise apply to the management of pelvic relaxation in the female.

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Note: Our data on results of Pereyra's operation have been submitted for publication.

Ring-a-ding-ding

One of the unsung heros of the current physician shortage is the telephone. Though its infernal ring rankles in us and wrecks havoc with our private lives and with our office tranquillity, still we could not and would not do without the electronic beast. How else could we so easily comfort our patients, make appointments, answer questions, and give sage advice — gratuitously? How else could we so easily follow up some of our problem patients, or deal with some emergencies, or prescribe?

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The answer to this spate of questions is: "Yes, the diagnosis is in question; one could be missing a serious illness or complication; and a physician may be evading his responsibility to his patient. But if by careful questioning he is reasonably sure of his grounds, and if he undertakes to follow the patient carefully, then there is no reason why he should not advise *and* prescribe if necessary."

Thus the telephone becomes a tool to extend a physician's services, and like any other effective tool it must be used with skill, judgment and caution lest it do harm—*Westchester Medical Bulletin.*

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Electrocardiogram of the Month

Bilateral Bundle Branch Block

Edward K. Chung, M. D., and Edwin J. Morgan, M. D.

THE underlying lesion of complete A-V Block is not uncommonly anatomic bilateral bundle branch block (BBBB).[1, 2] This is usually due to degenerative fibrosis of both bundle branches or, less often, the bifurcation. These degenerative changes are poorly understood, but are believed to be due to the cumulative effects of mechanical wear and tear during the aging process. They do not appear to be related to ischemia,[1, 3] although this may be a contributing factor in one third of cases.[4]

Recognition of BBBB is important, because this may lead to complete A-V block and the patient may develop Adams-Stokes syndrome at any time.

The purpose of this paper is to report a case of BBBB and to discuss briefly related literature.

The Authors

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- **Edwin J. Morgan, M. D., Resident in Medicine, WVU Medical Center.**

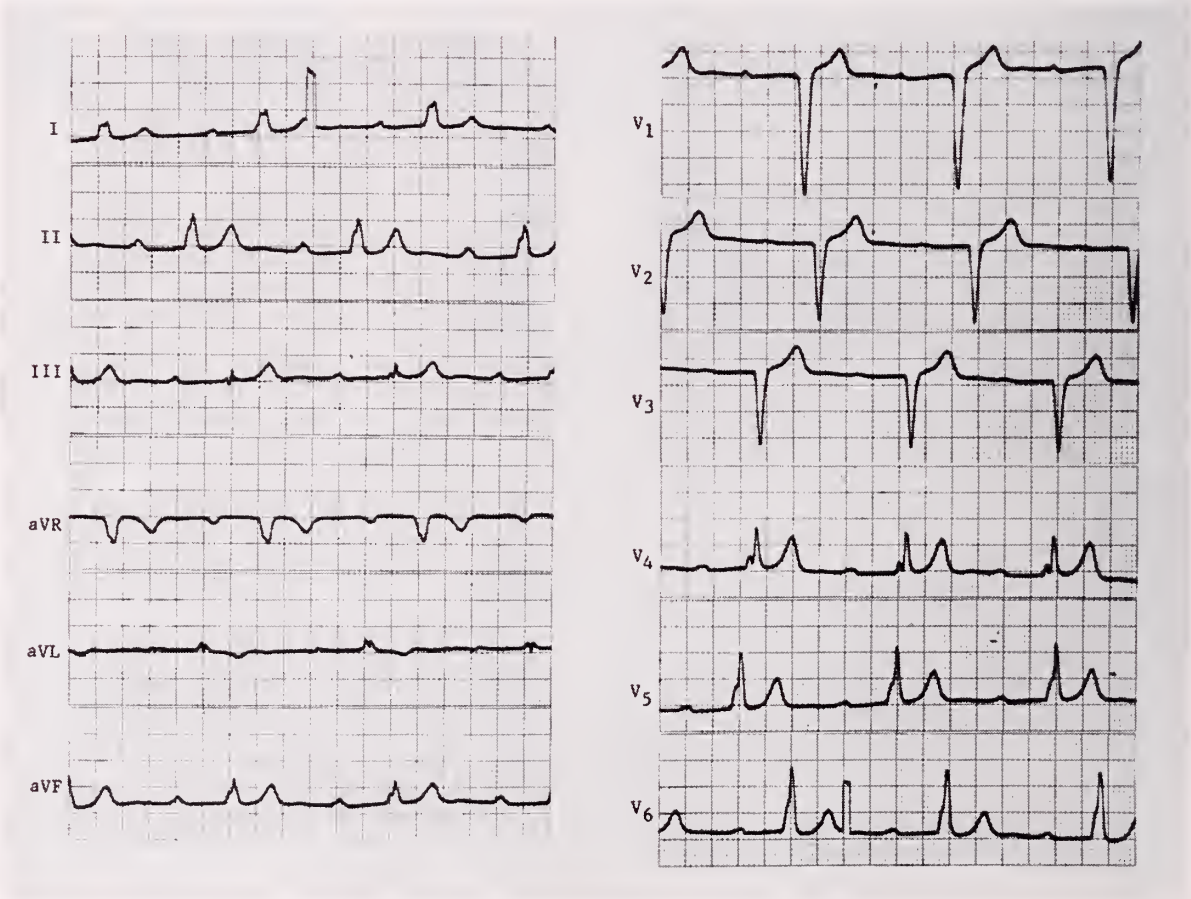

Figure 1. Sinus bradycardia (rate: 50/min) with first degree A-V block (P-R: 0.42 second) and left bundle branch block suggesting bilateral bundle branch block. In addition, T waves are symmetrically upright in precordial leads indicating anterior myocardial ischemia.

Case History. W. S., a 63-year-old chemist was referred to the Cardiac Clinic of the West Virginia University Medical Center for evaluation of intermittent slow heart rate. Approximately three weeks prior to his visit to the clinic, his local physician had noticed a heart rate of 40/minute and allegedly told the patient he had intermittent complete A-V block. He was given sublingual Isuprel for this slow heart rate. When this patient was seen in the clinic, he was completely asymptomatic. Physical findings were unremarkable except for a slow but regular heart rate of 48/minute.

He was able to work daily, his usual heart rates being between 48 and 60 per minute.

His electrocardiogram showed first degree A-V block, P-R: 0.42 second, with complete left bundle branch block (LBBB) suggestive of BBBB (Figure 1). In addition, T waves were upright in all precordial leads suggesting anterior myocardial ischemia.

He was advised to visit our clinic at three-month intervals for follow-up evaluation.

Discussion. Various electrocardiographic patterns may indicate BBBB (Table 1). BBBB often affects A-V conduction producing A-V block of varying degrees.[1-9] BBBB effects the QRS configuration and P-R interval in several different ways depending on the location and degree of damage to each bundle.[2] If right or left bundle branch block is associated with first degree A-V block, as seen in present case, BBBB is always a possibility particularly in elderly individuals. In this circumstance, right or left bundle branch block pattern will appear in the presence of first degree A-V block depending upon which bundle branch is more diseased.

"Masquerading bundle branch block" is a rare manifestation of BBBB and its mechanism is not clearly understood. This is frequently present following extensive myocardial infarction and may be complicated by Adams-Stokes seizure.[2] Alternating left and right bundle branch block is thought to be due to alternate impairment of conduction in the right and left bundles, both of which are assumed to be partially destroyed.[5,9]

Summary. A case of BBBB manifested by first degree A-V block with left bundle branch block has been presented. Various electrocardiographic patterns which may indicate BBBB also were discussed.

It should be noted that BBBB may lead to complete A-V block associated with Adams-Stokes seizure which requires urgent medical attention.

TABLE I

I. **A-V Conduction Disturbances**
   - A. Complete A-V Block
   - B. Advanced A-V Block without Wenckebach Phenomenon
   - C. Mobitz Type -II A-V block
   - D. First Degree A-V Block with Right Bundle Branch Block or Left Bundle Branch Block

II. **QRS Patterns**
   - A. Masquerading Bundle Branch Block (Left Bundle Branch Block in Limb Leads and Right Bundle Branch Block in Precordial Leads or Vice Versa)
   - B. Alternating Left and Right Bundle Branch Block
   - C. Right Bundle Branch Block with Left Axis Deviation
   - D. Left Bundle Branch Block with Right Axis Deviation

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God hides things by putting them near us.

Ralph Waldo Emerson

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The President's Page

Guest Author, Mrs. John A. B. Holt, President,
Woman's Auxiliary to the West Virginia
State Medical Association

AS OTHERS SEE US

DOCTORS' wives who are members of the Medical Auxiliary are often encouraged to pause and consider just what that membership really means.

Not only does the doctor's wife honor her husband's profession by belonging to this special group, but she also shares to a degree the problems as well as the rewards of that profession in a real and responsible way. Since she is an active ambassador in the field of medicine, she must, in her daily contacts be ever mindful of the attitudes she creates in others as she attempts to present the cause for individual freedom, especially as it relates to our nation's health. She may have no particular talent for crusading, but her closeness to medicine makes Auxiliary work a personal thing to her. As a member of the Auxiliary she is part of an organization with a standard of values held by no other group. She must be fully aware that many of the concepts that people have about medicine are in her hands at the community level whether she wishes it or not, and that any public relations program for medicine is of no avail in her small world if her friends and neighbors have a poor opinion of her. As she upholds the dignity and safeguards the reputation of her husband, so it is her mission—collectively with other doctors' wives—to preserve the rights and ideals of organized medicine.

Dr. Dwight L. Wilbur, President of the American Medical Association, told Auxiliary representatives to the Fall Conference in Chicago: "We physicians turn to you for help in serving as a liaison between the profession and the public. You well know that physicians do not have time to take part in all civic and political affairs that need their attention. We call on you to be medicine's representatives in many of these programs."

As Auxiliary members we feel deeply honored to be a part of the world of medicine, and will strive always to be a source of strength to a noble profession.

The 30th of March is Doctors' Day. On that day we are privileged to give special recognition to our physician husbands, who are dedicated to unselfish service and concern for others.

Jean S. Holt

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EDITORIALS

THE SPIRIT OF MORGANTOWN

In the continuing effort to maintain a line of communication between the private practitioner in Backwoods, West Virginia, and the academic community in Morgantown, much progress is being made.

For much of this progress we are indebted to the likes of Dean Sleeth, Provost Andrews, Assistant Dean Morgan, and Dr. Pat A. Tuckwiller of Charleston, the durable Chairman of our Association's Committee on Medical Education and Hospitals.

These men and others, including the late Dr. Charles L. Wilbar, Jr., were largely responsible for arranging a series of meetings in Morgantown almost a year ago that brought town and gown together to deal with certain problems in medical education.

These meetings were billed as the West Virginia Conference on Graduate Medical Education, First and Second Sessions, and they were held at the West Virginia University Medical Center in March and May.

At first only one such meeting was planned. The program called for hospital administrators and directors of internship and residency programs—both at the University and community hospital level—to explore together the problems of graduate medical education in West Virginia and possibly to arrive at some answers. However, the problems proved to be so vast and the discussion so spirited that time expired without any attention being given to solutions.

The second session about two months later was devoted to solutions. One major recommendation to emerge called for a union of the 12 hospitals in West Virginia which offer AMA-approved internship and residency programs.

The possibilities are obvious. Through coordinated activity, it could well be that these "teaching" hospitals, upon which we rely heavily for our supply of physicians in West Virginia, may find ways to solve, or at least lessen, their own problems without outside help.

Simply stated, the object is to get more intelligent, warm bodies into our internship and residency programs through improvement and enrichment and—yes, some salesmanship. Obviously, the more young doctors we attract to our graduate programs, the more we can expect to stay around in private practice later.

On March 13, almost a year after these discussions in Morgantown took place, the organized effort will be born. The West Virginia State Medical and Hospital Associations' Joint Council on Teaching Hospitals will organize itself in Charleston, roll up its sleeves, and go to work. Both medical staff members and administrative officials of the 12 hospitals, as well as certain others, will participate.

This effort deserves the unqualified support of each and every physician in West Virginia

who is concerned about who is going to take his place when his time is up.

The birth of the Joint Council on Teaching Hospitals is but one manifestation of what can be accomplished when town and gown work together on problems which concern both.

After last spring's meetings, one respected downstate physician was heard to remark that never before in his experience had the academic community extended the hand of cooperation so sincerely and explicitly to the community of private practice.

This was the Spirit of Morgantown. May it thrive and endure forever!

TIMELY REMINDER

Such things as drug profits and brand names have been held up to criticism. But, a name of which to be proud and a profit on which to operate are the mainsprings of the successful drug firm's existence—a firm that at this moment may be developing a drug that will one day save a life in your family.

There was a time when news of a possible flu epidemic would be cause for deepest alarm. That was before the day of vaccines. Like many other things, vaccines are there when we need them, so little thought is given to their source. Since we may owe our lives to them, it is well to be reminded of some facts about the modern pharmaceutical industry—and modern medicine. Both may fairly be said to have begun in the 1930's, when the sulfa drugs were introduced. These were the first "magic bullets" to attack specific germs that cause widespread disease.

With the advent of the first sulfa drugs, a great research explosion in the physical and life sciences was underway. The prescription drug industry has been largely responsible for the development of a whole family of lifesaving drugs. Unfortunately, the consuming public remains a stranger to the work of drug companies, since drug firms come in contact mainly with pharmacists and physicians rather than ultimate consumers. This may partly explain why political investigators of pricing and other practices of drug companies have had a field day in distorting the economic story of the drug industry. How many know, for instance, that an average of around 10 per cent of sales is earmarked for research. During 1966, the industry spent an average of $91,000 to support each doctorate-level professional or scientific individual in its research and development organization.—*The Clarksburg Telegram.*

C. L. WILBAR, M.D.
(1907-1969)

Quiet, Dedicated, Devoted, Intelligent, Perceptive . . .

These are among the adjectives that best described Dr. C. L. Wilbar, Jr., of Morgantown, who died unexpectedly on January 22.

Doctor Wilbar came to West Virginia as Director of the Regional Medical Program in 1967 after a long distinguished career in public health work in Hawaii and Pennsylvania. His work brought him into contact with scores of physicians all over the State.

Doctor Wilbar will be missed not only by his colleagues here in West Virginia but by fellow physicians from coast to coast who had the privilege of knowing him.

'I Don't Know'

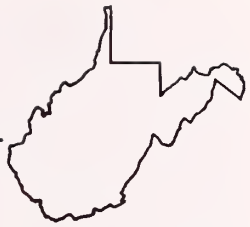
For a physician to tell his patient "I don't know" must represent a rather unusual, infrequent and for some doctors—an unknown experience. There may be many reasons why the doctor finds it virtually impossible to admit to his patient that he actually doesn't know the cause of symptoms. For some doctors it seemingly represents a completely unthinkable admission, since it might cause the patient to question the professional status of his physician.

It might be that a profound degree of humility is necessary for doctors to make this confession. Is the medical profession almost devoid of humble men? Patients often express the conviction that they would have more admiration and confidence in their doctor if he would only admit that he really didn't know what the trouble was. This viewpoint is probably very prevalent. It is conceded that there is a certain minority of patients whose attitude is such that an admission of this nature would immediately precipitate a search for another physician.

There was once a veterinarian who will always be remembered because of his ability to provide an almost instantaneous, unequivocal diagnosis on any occasion. It may be added that a few physicians in this category have also been encountered. Most people probably don't expect their doctor to come up with an exact diagnosis, particularly on the first examination or perhaps on the first few visits. Maybe the physician should have little reservation about freely admitting to his patient that he is unable to establish an immediate diagnosis. Could it be that a closer rapport might be established if we did not attempt to deceive patients by blithely making a definitive diagnosis on the very first visit, unless we can readily establish such a positive diagnosis?

Finally, it might be well to remember that it is no disgrace to confess that there are many occasions when we really don't know. Such a policy would not result in loss of face, but an improved physician-patient relationship—*J. Murphree, M.D., in the Journal of the Oklahoma State Medical Association.*

GENERAL NEWS



Drs. Papper and Krantz To Speak At 102nd Annual Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.

Emanuel M. Papper, M. D.

Kermit E. Krantz, M. D.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Dr. Emanuel M. Papper of New York City, and Dr. Kermit E. Krantz of Kansas City, Kansas, have accepted invitations to present papers during the three-day meeting.

Emanuel M. Papper, M. D.

Dr. Papper, Professor and Chairman of the Department of Anesthesiology at the College of Physicians and Surgeons of Columbia University, will appear as a speaker at the third general scientific session on Saturday morning, August 23. The session will be devoted to a Symposium on "Cardio-Respiratory Emergencies and Their Management." Also participating in the program will be an internist and a surgeon.

Doctor Papper, a native of New York City, was graduated from Columbia University and received his M. D. degree in 1938 from New York University School of Medicine. He interned and served residencies at Bellevue Hospital and served as a Fellow in Physiology at New York University. He was a member of the faculty at New York University prior to accepting his present position in 1949.

He served as a Major in the Medical Corps of the United States Army, 1942-46, and was Chief of the Section on Anesthesiology at Torney Dibble and Walter Reed Hospitals.

Doctor Papper was certified in 1943 by the American Board of Anesthesiology and served as President of the Board, 1964-65. He is a Past President of the American Society of Anesthesiologists and a member of the American College of Anesthesiologists, American College of Physicians and the Association of University Anesthetists.

He is the author of two books and has contributed more than 175 scientific articles to professional journals.

Kermit E. Krantz, M. D.

Dr. Kermit E. Krantz, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center, will appear as a guest speaker at the second general scientific session on Friday morning, August 22. His subject will be "The Placenta—Man's Best Friend."

A native of Oak Park, Maryland, Doctor Krantz was graduated from Northwestern University and received his M. D. degree in 1948 from Northwestern University School of Medicine. He interned at New York Lying-In Hospital and served residencies at that Hospital, Cornell Medical College and Mary Fletcher Hospital in Burlington, Vermont.

He served on the faculties at the University of Vermont College of Medicine and the University of Arkansas School of Medicine prior to accepting his present position in 1959.

Doctor Krantz was certified in 1955 by the American Board of Obstetrics and Gynecology and he is a member of the American College of Surgeons and the American College of Obstetricians and Gynecologists.

AMA President Honor Guest

Dr. Stark announced previously that Dr. Gerald D. Dorman of New York City, President Elect of the American Medical Association, has accepted an invitation to appear as a speaker at the first session of the Association's House of Delegates on Wednesday afternoon, August 20.

Doctor Dorman will be installed as President of the AMA at the annual convention in July.

Further details concerning the 102nd Annual Meeting at The Greenbrier will be announced in future issues of *The Journal.*

Winter Meeting of the Council In Charleston on Jan. 26

The Winter meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, January 26, 1969, with the Chairman, Dr. Richard V. Lynch, Jr., of Morgantown, presiding.

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, presented a report of a meeting which was held on Saturday afternoon, January 25. He reported that a number of bills of interest to the medical profession had been introduced early in the 1969 session of the West Virginia Legislature.

He said three highway safety bills had been introduced again this year after having been studied and recommended by the Legislature's Joint Committee on Government and Finance.

Doctor Holroyd said one bill would create a highway safety medical advisory board to assist the Commissioner of Motor Vehicles in the promulgation and implementation of medical standards necessary to determine the fitness of an applicant to operate a motor vehicle. A companion bill would make certain medical disorders reportable by the treating physician or health agency to the medical advisory board to the Department of Motor Vehicles for its use in determining the eligibility and capability of the person or persons being treated to operate a motor vehicle.

He said another bill in the package would require the use of certain safety equipment by motorcyclists.

The Council voted to approve and lend support to the above mentioned bills.

The Council also voted to support a bill which would permit local family planning clinics to give assistance to unwed women.

The Council voted to support a bill which would update the vital statistics law, as well as a bill to liberalize the requirements for foreign physicians to obtain a permanent license to practice in West Virginia and also authorize that the application fee be increased to $100 to cover the cost of the new FLEX licensure procedure.

Doctor Holroyd also reported that a bill had been introduced to establish a West Virginia Board of Examiners of Psychologists. The Council voted to support the bill provided it was approved by the Section on Neurology, Neurosurgery and Psychiatry and the West Virginia District Branch, American Psychiatric Association.

Pneumoconiosis Legislation

It was reported that several bills had been introduced in the Legislature relating to pneumoconiosis, or "black lung." Following a thorough review of the current controversy surrounding this condition, the following resolution was adopted unanimously by the Council:

"The Council of the West Virginia State Medical Association has received reports of discussion and controversy involving several physicians in the State, both members and non-members of the Association, who have become involved in political, economic and legislative activities associated with the occurrence of pneumoconiosis or "black lung disease" in the coal mining population of our State.

"The Council recognizes the responsibility and privileges of any physician to participate in such matters of general and professional interest, provided such participation and discussion is conducted with courtesy and objectivity.

"The Council is of the considered opinion that matters of such import as the health of any segment of our population require a complete unbiased evaluation of all factors involved and earnestly recommends to the legislative bodies of this State the appointment of a panel of experts in the field of pulmonary diseases to conduct a through objective study of the pathologic conditions under discussion, and to report their findings and recommendations to the Governor and the Legislature within a reasonable period of time.

"The West Virginia State Medical Association has a primary responsibility in all matters pertaining to the health of our population, or any segment thereof including those engaged in the coal mining industry, and pledges its active support and assistance in attaining an objective solution to the problem."

Doctor Mahood Named Member of Council

It was reported that Dr. W. Hampton St. Clair of Bluefield had submitted a letter of resignation as a member of the Council due to the fact that he planned to move out of the State within the next few months.

Accordingly, Dr. Richard W. Corbitt, the President, appointed Dr. John J. Mahood of Bluefield to succeed Doctor St. Clair for the unexpired term ending August 23, 1969.

Doctor Mahood, a native of Bluefield, received his M.D. degree in 1947 from the University of Virginia School of Medicine. He interned and served a residency at Detroit Receiving Hospital and also had postgraduate work in dermatology at Wayne University School of Medicine.

Doctor Mahood has been active in the affairs of organized medicine and served terms as Secretary and President of the Mercer County Medical Society.

Election of Honorary Members

The following physicians were elected to honorary membership in the State Medical Association:

Name	*Address*	*Society*
Hendrick A. Bracey	Welch	McDowell
William Ralph Counts	Welch	McDowell
Carl C. Romine	Morgantown	Monongalia

Liaison with SAMA Chapter

Drs. George F. Evans and Maynard P. Pride reported that they had appeared as speakers before recent meetings of the West Virginia University Chapter of the Student American Medical Association at the Medical Center in Morgantown.

Both physicians reported they received a warm reception and discussions with the students were most enlightening. They said the students expressed an

interest in becoming better informed about the State Medical Association and its component societies.

It was agreed that the State Medical Association should continue to furnish a speaker for the SAMA meetings on a monthly basis. Doctor Corbitt reported he had accepted an invitation to speak before the group in February.

Institute on Utilization Review

The Council voted to join with the West Virginia Hospital Association in co-sponsoring a second Institute on Utilization Review at The Daniel Boone Hotel in Charleston on Friday, March 14.

The decision to schedule another Institute was based on the success of the first meeting held three years ago. The program is structured especially for administrators, chiefs of medical staffs, chairmen of utilization review committees, and hospital trustees.

The following members of the Council were present:

Dr. Richard V. Lynch, Jr., of Morgantown, Chairman; Dr. Richard W. Corbitt of Parkersburg, President; Dr. Maynard P. Pride of Morgantown, President Elect; Dr. George R. Callender, Jr., of Charleston, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Richard E. Flood of Weirton, Councilor at Large; Dr. Seigle W. Parks of Charleston; Drs. Harry S. Weeks, Jr., of Wheeling; George A. Curry of Morgantown; S. Elizabeth McFetridge of Shepherdstown; Robert W. Bess of Piedmont; A. Kyle Bush of Philippi; Andrew J. Weaver, Clarksburg; R. L. Chamberlain of Buckhannon; William E. Gilmore of Parkersburg; William L. Neal of Huntington; Joseph A. Smith of Dunbar; A. Thomas McCoy of Charleston; and Worthy W. McKinney of Beckley; and Mr. William H. Lively of Charleston, Executive Secretary; and Mr. Edward D. Hagan of Charleston, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor of *The Journal;* Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Department of Mental Health; and Dr. John W. Hash of Charleston, a Past President of the Association.

Bronco Junction Schedules 1969 Camp Session

Bronco Junction, the rehabilitation camp for asthmatic boys, will go co-educational in 1969, according to Dr. Merle S. Scherr of Charleston, Medical Director.

Enrollment for the first eight-week camp session at the campsite in Putnam County in 1968 was limited to boys. However, both boys and girls between the ages of seven and sixteen will be eligible to attend this year's session, which begins on June 22.

Doctor Scherr urged physicians having asthmatic patients who might be candidates for Bronco Junction to refer them as soon as possible. Applications must be completely processed by May 15.

Camper fee for the eight-week session and follow-up in the home environment is $1,000, and credit plans are available. Scholarships are available in certain cases.

Doctor Scherr again urged physicians to consider spending some time as attending camp physicians.

Additional information may be obtained by writing to Dr. Merle S. Scherr, 805 Atlas Building, Charleston, West Virginia 25301.

Dr. Richard W. Corbitt of Parkersburg (right), President of the West Virginia State Medical Association, was an honor guest at the Kanawha Medical Society's Annual Dinner Dance and Installation of Officers, which was held in Charleston on January 25. Others in picture (left to right) are: Dr. E. Q. Hull of South Charleston, Retiring President of the Kanawha Society; Dr. Seigle W. Parks of Charleston, a Past President of the State Medical Association who presided at the installation; and Dr. A. Thomas McCoy of Charleston, the newly installed President. The plaque was presented to Doctor Hull.

Pediatric Society Announces Spring Program

The scientific program for the 1969 Spring Meeting of the West Virginia Chapter, American Academy of Pediatrics, has been announced by Dr. Meryleen B. Smith of Peterstown, Chairman of the Program Committee.

Jacqueline Noonan, M. D.

The session will be held Thursday and Friday, April 10-11, at the Holiday Inn in Princeton. Doctor Smith urges all persons who plan to attend the meeting to make their motel or hotel reservations early.

She also announced that members of the North Carolina and Virginia Pediatric Chapters are being invited to the West Virginia meeting.

The Thursday morning session will be devoted to a Chapter business meeting, with Dr. Forest A. Cornwell of Beckley, Chapter Chairman, presiding.

Doctor Cornwell will preside at the Thursday afternoon scientific session, which will be devoted to dental topics.

Thursday Afternoon Program

The Thursday afternoon speakers and their topics are as follows:

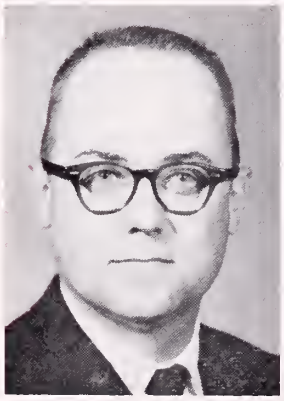
"Common Clinical Disorders of the Child's Mouth With Special Consideration of the Handicapped Child"—Jacqueline Noonan, M. D., Associate Professor of Pediatrics, University of Kentucky College of Medicine, Lexington.

"Clinical Advances in Pedodontia"—Stanley Poleway, D. D. S., Practicing Pedodontist, Charleston.

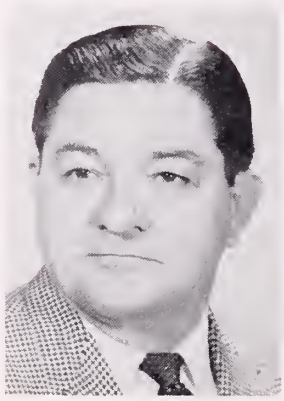
"The Modern Orthodontic Approach"—H. E. Kiser, Jr., D. D. S., Practicing Orthodontist, Bluefield.

Thursday Evening Program

There will be a social hour and banquet on Thursday evening. The after-dinner speaker will be State School Supt. Rex M. Smith.



H. E. Kiser, D.D.S.



Stanley Poleway, D.D.S.

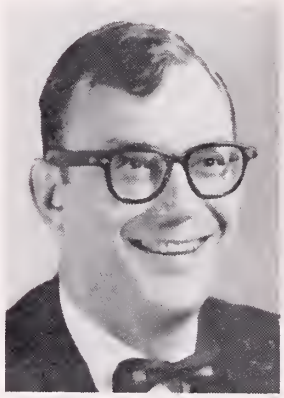
Friday Morning Session

Dr. Carl Barger of Bluefield will serve as Moderator for Friday Morning's Scientific Session. Speakers and their subjects are as follows:

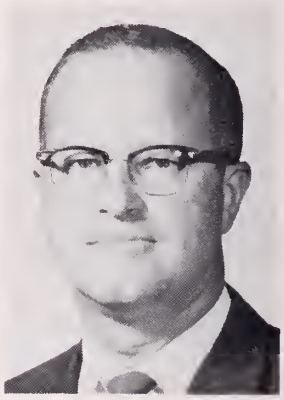
"The Battered Child Syndrome"—W. E. Copenhaver, M. D., and Mary R. Shupe, R. T., Department of Radiology, St. Luke's Hospital Bluefield. (There will be a case presentation by a Resident in Pediatrics at the West Virginia Medical Center.)

"Pediatric Interviewing; Psychological Parameters"—Steven J. Ruma, Ph.D., Assistant Professor of Pediatrics and Psychology and Director of Psychology Education, Children's Hospital, Ohio State University College of Medicine, Columbus.

"Adolescents and Drug Abuse"—John Kelley, M.D., Departments of Psychiatry and Pediatrics, WVU Medical Center.



Herbert L. Eckert, M.D.



W. E. Copenhaver, M.D.

Friday Afternoon Program

Dr. William Bruch will moderate the final scientific session on Friday afternoon, when speakers and their titles will be:

"Antimicrobials '69"—John P. Utz, M. D., Professor of Medicine, Medical College of Virginia, Richmond.

"Advances in Management of the Hemophiliac"—Mabel Stevenson, M. D., Department of Clinical Pathology, WVU Medical Center.

"Newer Aspects of Virology"—Herbert E. Eckert, M. D., Associate Professor of Preventive Medicine and Pediatrics, WVU Medical Center.

West Virginians Elected to ACP

Three West Virginia internists have been elected to Associate Membership in the American College of Physicians.

They are: Drs. Zeb C. Burton, Jr., of Huntington; James T. Hughes of Ripley; and Frank E. Medford of Charleston. All are members of the West Virginia State Medical Association.

Heart Assn. Names Field Workers

Two new field representatives have been appointed to the staff of the West Virginia Heart Association, according to Executive Director Richard Bates of Charleston.

Mrs. Ruth Gainer, a resident of Huntington for several years, will serve the eastern part of the State, and Mr. Robert Hays of Grantsville will have responsibility for the western section.

League for Nursing Lists April Meeting

"The Consumer in Today's Health Market" will be the theme for the annual convention of the West Virginia League for Nursing, which will be held at Holiday Inn No. 1 in Charleston, April 8-9.

Speakers on Tuesday, April 8, will include: Dr. James R. Kimmey, Executive Director, Community Health, Inc., New York; Miss Elizabeth V. Hallanan, Executive Director of the West Virginia Association of College and University Presidents, Charleston; and Dr. Samuel T. Habel, Professor of Sociology, Marshall University, Huntington.

There will be a banquet that evening, and the principal speaker will be Dr. Marion Murphy, Dean of the School of Nursing, University of Maryland.

The session on Wednesday morning, April 9, will be devoted to a panel discussion of "Problems in Bringing Health Services to the Consumer," and the Moderator will be Sister Rita Marie VonBerg, Administrator of St. Joseph's Hospital in Parkersburg.

Panelists will be: Dr. Ralph Nestmann of Charleston, a member of the Community Council of the Kanawha Valley; Miss Dorothea McLaughlin, Director of Information and Referral Service Bureau of the Community Council; Miss Annunciata Lepore, Director of the Visiting Nurse Association, Charleston; Mr. Eugene Staples, Director of University Hospital in Morgantown; and Mr. Dudley Rumbaugh of Blue-Cross-Blue Shield in Charleston.

Registration is $5 for members of the league and $7.50 for non-members. The charge for the banquet is $5 per person.

Cardiac Nursing Care Course At Medical Center

A third nursing education course entitled "Nursing in Cardiac Care Units" will be offered at the West Virginia University Medical Center this spring, probably beginning April 7.

The course will extend for three weeks. There will be no tuition fee, and educational materials will be furnished free of charge to students, but hospitals sponsoring the nurses will be expected to provide funds to reimburse them for travel and subsistence costs.

First preference for enrollment will be given to those nurses who could not be accommodated for the second course, which was conducted in January. Seventeen nurses from 10 different hospitals participated.

Dr. Robert J. Marshall, Professor of Medicine and Chairman of the Division of Cardiology, will direct the course. Members of Doctor Marshall's staff and the nursing staff will provide instruction.

Emphasis will be placed on the recognition of rhythm disturbances. Other topics will include the anatomy and physiology of the heart and circulation; the pathology of life-threatening heart diseases; pharmacology of important cardiovascular drugs; cardiopulmonary resuscitation; and nursing aspects of acute cardiac care.

Additional information may be obtained by writing to: Mrs. Sue Castle, Cardiac Training Assistant, Cardiac Care Unit Nursing Education Course, Room 2203, WVU Medical Center, Morgantown, West Virginia.

Looking Back 10 Years . . .

This picture was taken during the West Virginia State Medical Association's 1959 Annual Meeting, and shows some of the guest speakers that year. Left to right: Dr. Elvis J. Stahr, Jr., then President of West Virginia University and later Secretary of the Army under President John F. Kennedy and President of Indiana University; Dr. Richard J. Lilly, then State Director of Mental Health; Gov. Cecil H. Underwood; Dr. George F. Evans of Clarksburg, who was President of the Association at the time; and Dr. Louis M. Orr of Orlando, Florida, then President of the American Medical Association.

17th Annual Clinical Meeting Of Ob.-Gyn. College

The 17th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Americana Hotel in Bal Harbour, Florida, next April 28 through May 1.

Twelve postgraduate courses will be conducted immediately prior to the meeting on April 26-27.

Both the clinical meeting and the postgraduate courses are open to all physicians regardless of specialty.

The scientific program—in the form of formal papers, colloquia, panel discussions, correlated seminars, luncheon and breakfast conferences, and reports on current investigations—will cover virtually every topic in obstetrics and gynecology. There will also be new motion pictures and 250 industrial and scientific exhibits.

The program will be presented by about 500 physicians, and some 3,000 doctors are expected to attend the meeting.

Registration fee for non-members of the College is $50 for the clinical meeting and $45 for the postgraduate courses.

Additional information may be obtained by writing to: Meeting Services Department, American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago, Illinois 60603.

State Public Health Conference In Charleston in May

The Annual State Health Conference, sponsored jointly by the State Department of Health and the West Virginia Public Health Association, will be held at The Daniel Boone Hotel in Charleston, May 7-9.

Activities on Wednesday, May 7, will include the meeting of the West Virginia Association of Registered Sanitarians, the dinner meeting of the Executive Council, and the Sanitarians Party.

Dr. Richard McGraw, Deputy Assistant Secretary of Health Manpower, U. S. Department of Health, Education and Welfare, will keynote the General Session on Thursday.

Other speakers will include: Dr. Jerome S. Beloff; Lucy M. Cohen, Ph. D.; Dr. Morris F. Collen, Director of Medical Methods Research, The Permanente Medical Group, Oakland, California; Jerrold Michael, Assistant Administrator, Bureau of Consumers Protection and Environmental Services.

Sectional meetings will be held on Thursday and Friday afternoons.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Welfare, Compensation Chiefs Named by Governor

The appointments of two young men to head the State Department of Welfare and the Workmen's Compensation Fund were announced recently by Gov. Arch A. Moore, Jr.

Fred L. Davis, Jr.

Edwin F. Flowers

Governor Moore selected Edwin F. Flowers, 38, of New Cumberland, as his Welfare Commissioner and Fred L. Davis, Jr., 32, of Parkersburg, as Compensation Commissioner. Both appointees are attorneys.

In addition, Governor Moore announced the reappointment of Dr. Mildred M. Bateman of Charleston as Director of the Department of Mental Health, a post she has held since 1962. Doctor Bateman was originally appointed by Gov. W. W. Barron and was retained in the succeeding administration of Gov. Hulett C. Smith.

Edwin F. Flowers

Mr. Flowers, a partner in the New Cumberland law firm of Jordan and Flowers, succeeds L. L. Vincent as Welfare Commissioner. He was educated in Hancock County schools and holds A.B. and LL.B. degrees from West Virginia University.

He is a member of the Hancock County Bar Association, the West Virginia State Bar, the West Virginia Bar Association, the American Bar Association and the American Judicature Society.

In 1954-56, he served as assistant and acting staff judge advocate at Nellis Air Force Base, Nevada.

A native of New Cumberland, Mr. Flowers is active in religious, civic, business and political activities in the Northern Panhandle.

Fred L. Davis, Jr.

A native of Parkersburg, Mr. Davis was appointed to succeed Cletus B. Hanley as Compensation Commissioner. He earned A.B. and LL.B. degrees from West Virginia University and is a partner in the Parkersburg law firm of McDougle, Davis and Morris.

He is a member of the Wood County Bar Association and is currently a member of the Standing Committee on Civil Rules and the Committee on Unlawful Practice of the West Virginia State Bar. His other professional memberships include the West Virginia Bar Association and the American Bar Association.

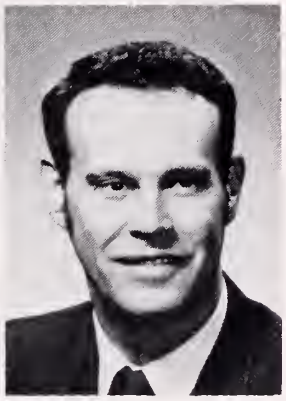
In his community, Mr. Davis is active in the Wood County Society for Crippled Children and Adults, the Boys' Club of Parkersburg, the Wood County Heart Association and the Wood County Tuberculosis League.

Administrators Are Named For Southern Program

Four members of the West Virginia State Medical Association have been appointed to key positions in the Southern West Virginia Regional Health Council's multi-million-dollar health care program.

Drs. N. Allen Dyer and Jean B. Neilson, both of Bluefield, and Drs. James O. Merritt and D. Alene Blake, both of Beckley, received the appointments.

Jean B. Neilson, M. D.



N. Allen Dyer, M. D.

D. Alene Blake, M. D.

James O. Merritt, M. D.

Doctor Dyer, son of State Health Director N. H. Dyer, will head the Community Health Services Division of the program, which embraces the counties of Mercer, Mingo, McDowell, Monroe, Fayette, Raleigh, Logan, Summers and Wyoming.

This division will be concerned with tuberculosis control, home nursing services, maternal and child health, child heart screening, vaccination, 24-hour referral service, solid waste disposal, dental health, public health staffing, health education, and manpower and training.

A native of McDowell County, Doctor Dyer attended West Virginia University and received his M. D. degree from the Medical College of Virginia. He also holds a Master of Public Health degree conferred by the University of North Carolina.

Doctor Neilson, a pediatrician, is in charge of the Maternal and Child Health Project. She received her M. D. degree from the University of Tennessee College of Medicine, and is married to Dr. Robert Neilson, a thoracic surgeon in Bluefield.

Doctor Blake, who is married to Doctor Merritt, directs the Program's Mental Health Division. She received her medical degree from the Medical College of Virginia and practiced in Oak Hill prior to entering a psychiatric residency program a few years ago.

Doctor Merritt is in charge of the Clinical Program. He received his M. D. degree from the University of Iowa Medical School and also served a residency in psychiatry.

Rheumatic Disease Symposium In Louisville

The Fifth Annual Rheumatic Disease Symposium, sponsored by the University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation, will be held on Thursday, April 10.

"What's New in Rheumatic Diseases" will be the theme of the symposium at the Louisville General Hospital, University of Louisville Medical Center.

Several nationally prominent authorities on rheumatology will participate in the discussion. The conference will emphasize specific topics of current interest, including recent advances in diagnosis and treatment of rheumatoid arthritis, osteoarthritis, crystal induced synovitis, special forms of periodic arthritis and new surgical approaches to arthritis.

There will be no registration fee. Programs and other information may be obtained by writing to: Symposium Program Committee, Kentucky Arthritis Foundation, 209 Speed Building, Louisville, Kentucky 40202.

Dr. Richard W. Corbitt of Parkersburg (left), President of the West Virginia State Medical Association, did not have to travel far to pay his official visit to the Parkersburg Academy of Medicine on January 9. Doctor Corbitt was guest of honor at his own medical society, as was Mrs. John A. B. Holt of Charleston (second from right), President of the Woman's Auxiliary to the West Virginia State Medical Association. Others in picture are Mrs. Rex Dauphin, President of the Woman's Auxiliary to the Parkersburg Academy; and Dr. Charles Barnett, President of the Academy.

Utilization Review Meeting In Charleston, March 14

The second West Virginia Institute on Utilization Review will be held at The Daniel Boone Hotel in Charleston on Friday, March 14.

The program is being sponsored by the West Virginia Hospital Association and the West Virginia State Medical Association, and is structured especially for hospital administrators, chiefs of medical staffs, chairmen of utilization review committees and hospital trustees.

Susan S. Jenkins

Jesse L. Lynn

There will be a registration fee of $10, which includes admittance to a reception Thursday evening, March 13, and a luncheon on Friday.

Dr. Richard W. Corbitt of Parkersburg, President of the State Medical Association, will preside at the Friday morning session, which is scheduled to begin at nine o'clock. Mr. Joseph E. Peery, Jr., President of the West Virginia Hospital Association, will preside in the afternoon.

Speakers and their topics will be as follows:

"Background, Purposes and Functions of Utilization Review"—Dr. Theodore C. Bedwell, Chief Medical Officer, Bureau of Health Insurance, Social Security Administration.

"Effective Utilization Review in Medicare"—Dr. Robert Travnicek, Medical Consultant, U. S. Public Health Service.

"Current Problems, Emphasis, and Projections for Medicare"—Susan S. Jenkins, Professional Relations Specialist, Bureau of Health Insurance, Social Security Administration.

"Role of Fiscal Intermediaries, State Agency and Regional Office in Utilization Review"—Jesse L. Lynn, Regional Representative, Bureau of Health Insurance, Charlottesville, Virginia.

"Legal Liability of Physicians, Hospitals and Extended Care Facilities in Utilization Review"—Paul L. Selby, Dean, West Virginia University School of Law, Morgantown.

Additional information about the program may be obtained by writing to Mr. William R. Huff, Executive Vice President, West Virginia Hospital Association, 1219 Virginia Street, East, Charleston 25301.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

March 13-15—AMA-ABA Medicolegal Symp., Las Vegas.
March 15-19—Am. Acad. of Allergy, Bal Harbour, Fla.
March 21-22—AMA Rural Health Conf., Philadelphia.
March 28-29—AMA Cong. on Socio Economics of Health Care, Chicago.
March 31-April 2—Am. Assn. for Thoracic Surgery, San Francisco.
April 9-11—Maryland Medical, Baltimore.
April 10-11—W. Va. Chap., Am. Acad. of Ped., Princeton.
April 13-17—Am. Assn. of Neur. Surg., Cleveland.
April 16-19—W. Va. Chap., ACS, White Sulphur Spgs.
April 18-20—Am. Soc. of Int. Med., Chicago.
April 20-23—W. Va. Acad. of Oph.-Otol., White Sulphur Springs.
April 21-23—Am. Acad. of Ped., Boston.
April 21-25—ACP, Chicago.
April 21-26—Am. Acad, of Neurology, Washington.
April 25-27—W. Va. Chapter, AAGP, Wheeling.
April 28-May 1—Am. Col. of Ob. & Gyn., Bal Harbour, Florida.
April 30-May 1—Am. Ped. Soc., Atlantic City.
May 5-7—Am. Gyn. Soc., New Orleans.
May 5-9—Am. Psychiatric Assn., Miami Beach.
May 6-7—Assn. of Am. Phys., Atlantic City.
May 12-15—Am. Urological Assn., San Francisco.
May 12-16—Ohio Medical, Columbus.
May 24-26—Am. Thoracic Soc., Miami Beach.
May 26-28—Am. Oph. Soc., Hot Springs, Va.
June 2-6—Am. Col. of Allergists, Washington.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.
July 11-12—Rocky Mtn. Cancer Conference, Denver.
July 13-17—AMA, New York.
Aug. 18-20—Am. Hosp. Assn., Chicago.
Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical. Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.
Oct. 6-12—ACS, San Francisco.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 11-15—Am. Col. of Prev. Med., Detroit.
Nov. 30-Dec. 3—AMA Clinical, Denver.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.
Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

The West Virginia Medical Journal

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Cervical Spondylosis: The Neurological Mimic*

Thomas W. Langfitt, M. D.

The most common signs and symptoms of cervical disk disease are well known and frequently are divided into two major categories —the brachialgic syndrome, consisting of pain and neurological deficits in the upper extremities, and the myelopathic syndrome produced by compression of the spinal cord. Several other clinical manifestations of cervical spondylosis are less well appreciated. Although several of these syndromes are uncommon, others occur with sufficient frequency to warrant particular attention in differential diagnosis.

Some complications of cervical spondylosis mimic other disease entities, at times so precisely that the cervical spine is not considered. Dysphagia due to compression of the posterior aspect of the pharynx and upper esophagus by a large anterior cervical spur occurs rarely but may simulate a tumor or other mass lesion in or about the pharynx. Cervical nerve root compression can cause precordial pain with radiation into the left upper extremity that is similar to angina pectoris. The pain in both conditions may be aggravated by exercise, and there is evidence that nerve root compression, usually in the thoracic region, can cause EKG abnormalities in the absence of intrinsic heart disease.

Another Syndrome

Another syndrome caused by cervical spondylosis is pain in the head and face. When pain radiates from the posterior cervical region into the occiput and particularly when it is associated with radiation into the shoulder and upper extremity, its origin in a cervical nerve root is immediately suspected. When the pain is confined almost entirely to the head, however, and when it is described as aching rather than sharp and shooting, the patient is considered a problem in the differential diagnosis of headache, and the neck may not be considered. The pain is commonly unilateral but may spread to the opposite side or in rare cases may be diffuse and symmetrical. Most commonly it is located in the occipital region with radiation into the forehead and temple. The most difficult cases to diagnose are those with pain confined to the face. A diagnosis of atypical facial neuralgia frequently is made, and since this usually implies a functional origin for the patient's complaints, his chances of having a proper diagnosis made in the future are greatly reduced. Another feature of the headache and facial pain produced by cervical disk disease is the presence of autonomic phenomena which may be quite prominent. Flushing of the face, lacrimation, sweating, and either enlargement or constriction of the pupil may be part of an acute attack. Here the picture may resemble cluster headaches.

Mechanisms Not Clear

The mechanisms responsible for the head pain produced by cervical disk disease are poorly understood. Many years ago Barre[1] introduced the concept that stimulation of the sympathetic nerves in the neck could produce this clinical picture and termed it the posterior cervical sympathetic syndrome. Since there is not convincing anatomical evidence for a sympathetic outflow from the spinal cord above the eighth

The Author

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cervical ventral root, it is difficult to attribute head pains to irritation of sympathetic fibers by disk lesions, nearly all of which occur above the C7 level. The annulus fibrosis, which surrounds the disk proper, and adjacent ligamentous structures are liberally supplied with pain fibers, and the central connections of these fibers are only partially known. Therefore, headache and perhaps precordial pain may be due in part to irritation of these sensory nerves and not to direct compression either of the ventral or dorsal roots.

In recent years compression of the vertebral arteries in the neck by laterally projecting spondylotic spurs has been demonstrated in a large number of cases, and some authors believe that this is one of the most common causes of vertebral-basilar insufficiency. Hutchinson and Yates,[2] in 1956, published the results of their examination of the entire length of the vertebral arteries in cadavers. They were primarily concerned with sites of predilection for atheromata, but they noted the presence of degenerative spurs projecting into the vertebral canal, at times markedly displacing the artery laterally and anteriorly. Although they did not observe total occlusion of the vertebral artery by the osteophytes, their observations suggested that the degree of compression might well be related to movements of the cervical spine. Thus, it appeared that spondylosis might be a cause of positional vertigo and other symptoms of brainstem vascular insufficiency. Tatlow and Bammer,[3] in a subsequent study, injected the vertebral arteries of cadavers with contrast material during movements of the head and neck. In some cadavers maximal rotation to either side produced partial occlusion of the vertebral arteries entering the intracranial space. This is the probable explanation for cases of brainstem vascular insufficiency induced by chiropractic manipulations. In addition, they demonstrated intermittent occulsion of the vertebral arteries in the neck by cervical osteophytes. Sheehan[4] et al then reported 26 cases of intermittent brainstem vascular insufficiency caused by vertebral artery compression from spondylotic spurs. Since many of the patients also had atherosclerosis, their symptoms probably were due to a combination of the two conditions.

On the basis of these and many subsequent observations, syndromes have been described which, if not pathognomonic of vertebral artery compression, are at least consistent with the diagnosis and indicate the need for careful evaluation of the cervical spine and for vertebral angiography. The most common complaints are dizziness and vertigo. The patient may not associate these symptoms with movements of the head unless an effort is made to elicit this aspect of the history. Most commonly the attacks are precipitated by looking upward or in turning to look over the shoulder as in backing an automobile. With the vertigo there is almost always ataxia, and a disturbance of gait may be the principal complaint. The patient states that his head feels fine but he can't make his legs work properly. Tinnitus, nausea and vomiting, dysarthria and dysphagia, and visual symptoms also may be recorded. Headache is common and may be so acute and severe as to suggest subarachnoid hemorrhage. A particularly interesting manifestation of vertebral-basilar insufficiency is "drop attack," a term coined by Kremer[5,6] for sudden loss of strength in the lower extremities. The patient falls suddenly to the ground, without any disturbance of consciousness, and shortly is able to get up under his own power and walk normally. The attack may be precipitated by turning of the head. Presumably these attacks are due to ischemia of the corticospinal tracts.

An interesting syndrome produced by early compression of the cervical spinal cord is pain in the back and lower extremities.[7] Usually the pains are attributed to lumar disk herniation, and the diagnosis is made more difficult by the high incidence of combined cervical and lumbar disk pathology. A case in point is a 63-year-old woman who was first seen in June, 1964, with a history of low back pain dating from 1956. In 1961, an aching, burning pain in the right buttock and posterior aspect of the right leg developed. This pain had become steadily worse in the few months prior to admission. Neither the back pain nor the leg pain was aggravated by exercise or by coughing and sneezing. Several years previously, she had had an attack of severe pain in the neck and one arm and stated that the arm had become useless for a period of several months. Strength in the arm then gradually returned, and she had had no further symptoms in the neck or upper extremities.

Examination of the spine revealed normal mobility without pain. The straight leg raising test was slightly positive at 90° bilaterally. The neurological examination was otherwise unremarkable. X-rays of the spine showed slight enlargement of the left C4-5 intervertebral foramen and marked narrowing of the L5-S1 interspace and encroachment on the S1 root sleeve on the right side. In the cervical region, a 1.5 cm. intradural mass lesion was present at the C4-5 level on the left. At surgery a dorsolateral meningioma was completely extirpated. Marked

compression and distortion of the spinal cord were present.

When the patient awakened from anesthesia, she stated that the pain in her back and leg had disappeared. She has not had recurrence of symptoms in the back or lower extremities in the four years since surgery.

Since our experience with this case we have had several additional patients with pains in the back and legs that were relieved by decompression of the cervical spinal cord. Spondylosis has been the cause in nearly all of the cases.

Helpful Features

Certain features in the history and examination are helpful in deciding whether back and leg pains originate in the cervical or the lumbar region. The pain produced by lumbosacral nerve root compression ordinarily begins in the back and extends down the leg in the distribution of the sciatic nerve. At times it is confined entirely to the leg or to the back, and in the small percentage of lumbar disk protrusions which occur above the L4 level, the pain is referred to the anterior thigh. It may be present in both legs but rarely is it equal in intensity. The pain is sharp and shooting, less commonly aching, and rarely burning. Paresthesias in the distribution of the involved nerve roots are common.

The pain symptoms of spinal cord compression differ from the above both in quality and location. The pain in the legs may be entirely aching and usually is described as deep and boring in contrast to the more superficial radiating pain of sciatica. The presence of a constant burning sensation is particularly strong evidence of cord involvement. Another important feature is the paucity of mechanical symptoms referable to the low back. The patients do not complain of limitation in back mobility. Aggravation of symptoms by exercise and by coughing and sneezing, and relief by bed rest, traction, or back brace, findings characteristic of lumbosacral nerve root compression, are not features of spinal cord pain. Night pain, which awakens the patient and is relieved by getting out of bed, has long been considered a symptom of spinal cord tumor. This is a frequent complaint of patients with spondylosis and cord compression and is an unusual symptom of lumbar disk disease.

Careful Neurological Examination Important

Although few of our patients have had neurological signs of spinal cord involvement, in many cases a careful neurological examination is the principal means whereby the origin of the patient's complaints is established. An extensor plantar response is evidence of involvement of the motor tracts and it may be the earliest sign of cord compression. A hemisensory deficit with a level in the abdominal or thoracic region is evidence of cord disease, but early on it often is absent or can be detected only by a careful examination. Unilateral weakness in dorsiflexion or plantar flexion of the foot is the most common sign of lumbar disk herniation, whereas proximal weakness bespeaks a spinal cord lesion. Asymmetry of reflexes in the lower extremities may be difficult to interpret. An absent ankle jerk is a common sign of S1 nerve root compression, and depression or absence of the knee jerk occurs frequently with L4 disk lesions. Since reflex amplitude varies greatly among patients, and within the same patient at different times, one may be hard put to decide whether the reflexes are pathologically hyperactive in one limb due to spinal cord compression or hypoactive in the opposite limb due to nerve root compression.

A major feature of lumbar disk herniation is aggravation of pain by further irritation or stretching of the nerve root. Thus, tenderness over the lumbar spinous processes, limitation in back mobility, and a positive straight leg raising test are more common signs of this condition than are neurological deficits secondary to destruction of nerve fibers. These signs are not associated with spinal cord pain and, when present, they are evidence of a process in the lumbar spine independent of the cord lesion. Finally, the most difficult cases to diagnose are those without a history of pain in the neck or upper extremities and no signs referable to the cervical spine. Therefore, myelographic visualization of the entire spine is mandatory in the cases of those patients who do not have a typical lumbar disk syndrome and in the cases of those patients who have ever had symptoms in the neck or upper extremities which suggest cervical spine disease.

In conclusion, cervical spondylosis may mimic a host of diseases by encroachment on the spinal cord and its nerve roots. Since intervertebral disk degeneration is one of the most common processes of aging, radiological findings of spondylosis are not sufficient evidence alone that the spondylosis is the cause of the patient's complaints. A careful neurological history and examination often will provide the clues to make a proper diagnosis. In many cases, however, the review is normal, and the diagnosis must be made by exclusion.

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Conservative Surgery for Mitral Valve Disease

Joseph C. Kiser, M. D.

In spite of recent advances in prosthetic valve design and construction, arterial embolization and mechanical dysfunction continue to be serious problems. In the mitral position, the hazard of embolization seems to be particularly severe, even with optimal anticoagulant control.[1] Perhaps more consideration should be given to repair of the existing valve when conditions warrant. In the absence of calcification or extensive loss of tissue substance of the anterior mitral leaflet, application of proven repair techniques may yield satisfactory results.

The following five case reports are examples of severe mitral disease treated by various reconstruction techniques. In three of these cases, multiple valve disease was present. All five patients are living and have shown early evidence of improvement.

Case Reports

Case 1.—L. H., 65-year-old female, functional class III-c, moderately cachetic, with known atrial fibrillation of ten years' duration. Grade IV apical holosystolic murmur and grade II apical diastolic murmur. No ascites, hepatomegaly, or peripheral edema.

Chest X-Ray and Cardiac Fluoroscopy.—Cardiomegaly with double contour of left atrial enlargement, minimal mitral valve calcification.

ECG.—Atrial fibrillation, right axis deviation with ST and T-wave changes consistent with digitalis effect.

Cardiac Catheterization.—Pulmonary artery pressure 60/25, wedge 35 (mean), cardiac output 1.5 L/min/m^2 (index). No aortic valve gradient. Aortic root injection revealed no aortic valve incompetence. Left ventricular injection demonstrated marked mitral regurgitation.

Surgery.—There was some calcification at the posteromedial commissure and a fixed orifice measuring approximately 2.0 x 1.5 cm. Commissural fusion was split to the annulus in both directions. There was marked subvalvular fusion of the chordae tendinae. The anterior papillary muscle was incised longitudinally between the chordae and a posteromedial annuloplasty was performed. There was no systolic thrill over the left atrium at the conclusion of the procedure.

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The immediate postoperative condition was satisfactory without any tendency toward the "low output syndrome". Her convalescence was slow but uncomplicated. Fluid retention did not occur. She was discharged from the hospital on the twentieth postoperative day.

Case 2.—Fifty-two-year-old female, functional class III with bilateral pleural effusions. Recent onset of atrial fibrillation. Grade IV systolic ejection murmur at the left sternal border, radiating into the base of the neck. Grade III holosystolic apical murmur radiating toward the axilla and audible in the back. Grade II blowing diastolic murmur heard along the left sternal border. No ascites, hepatomegaly or peripheral edema.

Chest X-Ray and Cardiac Fluoroscopy.—Cardiomegaly with evidence of left atrial enlargement. No valvular calcification seen.

ECG.—Atrial fibrillation, digitalis effect.

Cardiac Catheterization.—Confirmed the clinical diagnosis of severe aortic valve disease and marked mitral valve incompetence.

Surgery.—The aortic valve was found to be severely diseased and was replaced with a Cutter prosthesis. Mitral valve was predominantly stenotic with a central orifice measuring 7 to 8 mm. in diameter. There was minimal calcification in the posteromedial commissure. Commissures were split to the annulus in both directions and a posteromedial annuloplasty was performed.

The postoperative course was uncomplicated. At the time of dismissal from the hospital, there was a grade I apical systolic murmur.

Case 3.—Thirty-six-year-old female with recurrent mitral stenosis. Closed mitral commissurotomy had been performed eight years prior to this admission. Functional class II-b with increasing dyspnea on exertion in the past year and hemoptysis two months prior to this ad-

mission. Loud apical diastolic rumble with an opening snap audible.

Chest X-Ray and Cardiac Fluoroscopy.—Mitral configuration. No evidence of valvular calcification.

ECG.—Sinus rhythm, right axis deviation.

Surgery.—The valve was severely stenotic with a central orifice that measured approximately 7 mm. in diameter. There was no valvular calcification. The dilator was introduced and with the first attempt, the anterolateral commissure opened completely, but a severe rent occurred posteriorly and medially. This commissure was then incised with a knife and a posteromedial annuloplasty performed. At the conclusion, the diastolic thrill was gone and there was no systolic thrill palpable over the left atrium.

The postoperative course was uncomplicated and there were no murmurs audible at the time of dismissal from the hospital.

Case 4.—E. J., 71-year-old female, functional class IV. Rheumatic fever at age 15 years with symptoms of dyspnea on exertion being prominent at age 55 years. She had taken digitalis for 15 years. Progressively more severe dyspnea during the past four years and currently dyspneic at rest. Marked neck vein distention in the sitting position. Previous history suggestive of ascites. Grade IV holosystolic murmur at the apex, radiating to the axilla and audible in the back. Grade III systolic murmur along the lower right sternal border which seemed louder with inspiration. Liver enlarged and pulsatile. No ascites or peripheral edema evident.

Chest X-Ray and Cardiac Fluoroscopy.—Marked enlargement of all chambers with considerable enlargement of the right atrium. No valvular calcification seen.

ECG.—Atrial fibrillation.

Cardiac Catheterization.—Confirmed the clinical diagnosis of severe mitral incompetence and ruled out aortic valve disease. Right atrial pressure 18/8 Hg. with activity of the catheter in the right ventricle suggesting marked tricuspid incompetence. Severe pulmonary hypertension with a pulmonary artery pressure of 110/38. Unable to obtain a wedge pressure.

Surgery.—There was minimal calcification in the commissures of the mitral valve near the annulus. There was a fixed central orifice measuring approximately 2.0 x 1.0 cm. Both commissures were split to the annulus. There seemed to be adequate substance to the anterior leaflet, although the edge was rolled and there was moderate chordal thickening and fusion. A posteromedial annuloplasty was performed. There did not appear to be organic disease of the tricuspid valve. A tricuspid annuloplasty was performed by placing figure-of-eight stitches in the annulus between the anterior and septal leaflets. At the conclusion of the procedure, there was no palpable thrill over the left atrium, although there remained a thrill over the right atrium.

Her convalescence was prolonged but without specific complication. At the time of discharge, 22 days after surgery, there remained a prominent systolic murmur heard over much of the precordium, but not radiating to the axilla or to the back.

Case 5.—Fifty-eight-year-old male, functional class III with progressive deterioration in the past two years. Admitted in congestive heart failure. With appropriate diuretics, his weight dropped from 162 pounds to 147 pounds. Marked cardiomegaly with a hyperactive apical impulse in the seventh left interspace at the anterior axillary line. Grade V apical holosystolic murmur and a harsh grade IV systolic murmur in the aortic area. Soft grade II diastolic blowing murmur along the left sternal border. Liver slightly enlarged.

Chest X-Ray and Cardiac Fluoroscopy.—Marked cardiomegaly with evidence of left atrial enlargement, moderate calcification in aortic and mitral valve region.

ECG.—Sinus rhythm, left ventricular hypertrophy.

Cardiac Catheterization.—Confirmed the clinical findings of severe mitral incompetence and marked aortic stenosis and incompetence.

Surgery.—The mitral valve was exposed from the right and found to contain only minimal calcification. The posteromedial commissure was fused and there were several ruptured chordae along the posterior leaflet. Both commissures were completely opened by sharp dissection. The ruptured chordae were repaired and a posteromedial annuloplasty was performed. The aortic valve was replaced with a Cutter prosthesis.

His postoperative course was complicated by a right hemothorax requiring thoracentesis. He was dismissed on the 17th postoperative day. There was a grade II systolic murmur at the apex at the time of discharge which has since diminished.

Discussion

Mitral valve reconstruction was widely employed in the early days of open heart surgery. More recently, the major emphasis has been

on valve replacement with prosthetics of varying design and composition. In spite of the predictable hemodynamic results that can be anticipated with these prostheses, major problems still need to be overcome. Reported mortality rate figures for mitral valve replacement still are in the range of 15 per cent to 20 per cent with the "low output syndrome" accounting for a large percentage of these deaths. Accumulated data indicate that perhaps as many as 50 per cent of patients may experience systemic embolism within 36 months after mitral valve replacement with the standard Starr-Edwards prosthesis. Although the early reports with cloth-covered valves have been enthusiastic, the effectiveness of this innovation is yet to be proved. Valve ring detachment from the mitral annulus, ball variance, and bacterial endocarditis also occur.

Mitral valve reconstruction in many instances can produce satisfactory results. In the absence of heavy calcification or deficient tissue in the anterior leaflet, reconstruction may be preferable to replacement. Reliable techniques that can be employed include sharp division of commissural fusion, posteromedial annuloplasty, repair of ruptured chordae, direct suture of tears or perforations, and mobilization of subvalvular fused chordae by longitudinal incision of the papillary muscles. The hemodynamic improvement gained may be difficult to assess at the time of surgery, but one may be fairly certain that significant improvement has been obtained if the systolic thrill of incompetence over the left atrium is abolished. Rarely is the murmur of mitral insufficiency completely eliminated by these techniques. With time, however, the murmur does not often increase in intensity. Patients who have had successful mitral valve reconstruction do not require postoperative anticoagulation routinely, and systemic embolism is uncommon. Uncertain as we are regarding the etiology of the "low output syndrome", it does not often accompany mitral valve reconstruction. Recognizing the relatively rare incidence of this latter complication after mitral valve reconstruction, one might anticipate significant reduction in the operative mortality for mitral valve disease if the patients are properly selected and the techniques appropriately applied.

Our group of patients is small in number and the follow-up is short. There was one postoperative complication—a hemothorax requiring aspiration. Three of the mitral reconstructions were performed on patients undergoing surgery for multiple valve disease. Those patients who required concommitant aortic valve replacement have been maintained on anticoagulants. The "low output syndrome" did not occur and none of them required assisted ventilation during the postoperative period. Three of these five patients have residual aspical systolic murmur. There were no operative deaths.

Summary

1. In the absence of heavy calcification of severely deficient valve substance in the anterior leaflet, mitral valve reconstruction can provide satisfactory results.

2. The risk of postoperative arterial embolism is reduced.

3. The procedure can be accomplished with low operative mortaity.

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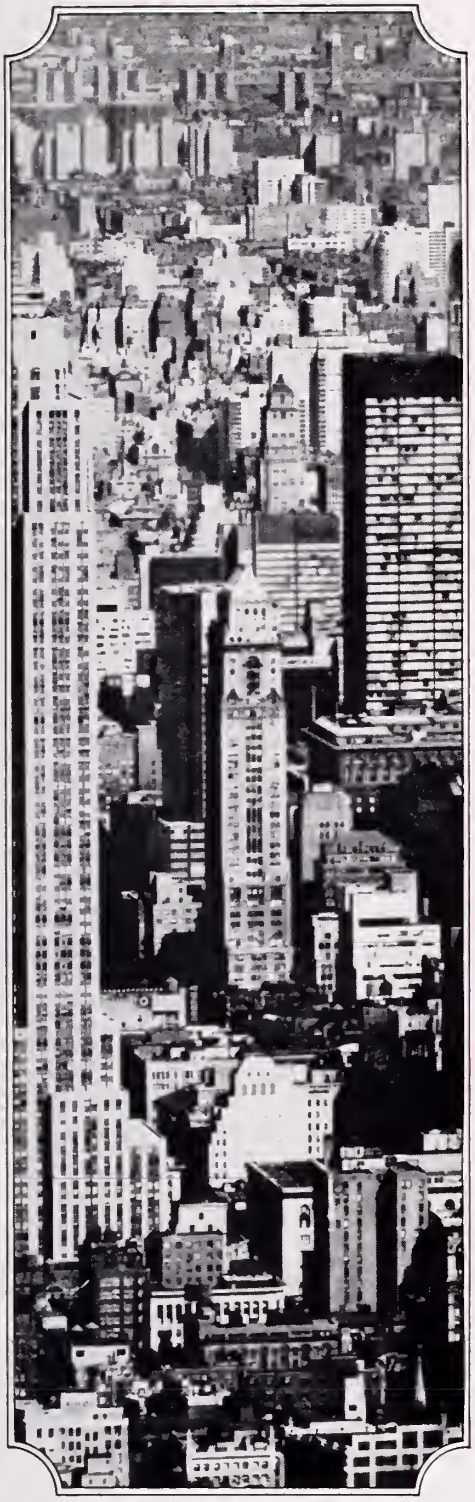
A theory is an educated hunch.

Arnold Glasow



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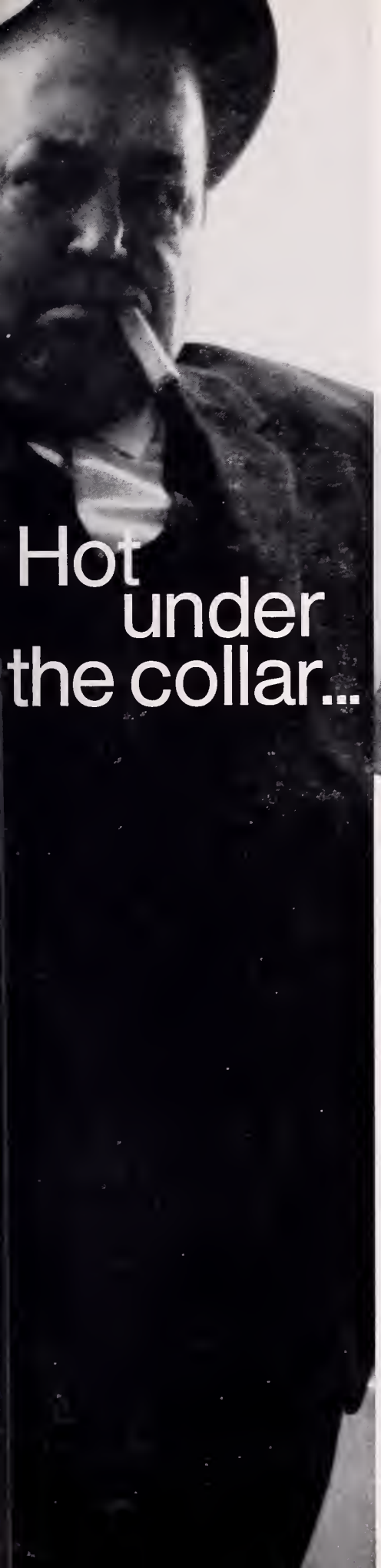

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Axillary Brachial Plexus Block—A Review

Walter D. Mazzacane, M. D.

THE purpose of this review is to reemphasize the fact that axillary brachial plexus block is the procedure of choice for surgical intervention or manipulation of the upper extremity, below the distal third of the humerus. It is easily and readily performed in any age group with a maximum of safety and with less fear of complications.

History.—Crile, of Cleveland, first injected the brachial plexus under direct vision in 1897. Hirschel injected the brachial plexus successfully through the axilla, "blind", in 1911. Kulenkampf, after experimenting on himself, devised the supra-clavicular technique in 1912. Patrick published his modification of the Kulenkampt technique in 1940. The axillary approach to the brachial plexus is discussed in this review.

Anatomy of the Axilla.—The axilla has been described as having the shape of a funnel or of a pyramid; the base of the axilla actually is placed distally and the apex is placed just below the middle of the clavicle. Through the vertex of the pyramid pass almost all of the vital structures of the upper arm and forearm.

The anterior wall of the axilla, as you know, is formed by the pectorialis minor and major muscles and the space between the pectoralis muscles and the lower end of the clavicle is occupied by the so-called coracoclavicular fascia. The posterior wall is formed by the subscapularis, teres major and latissimus dorsi muscles. The medial wall is formed by the chest cage and the serratus anterior muscle. The lateral wall is formed by the medial aspect of the humerus and is bounded by the coracobrachialis and biceps muscles.

Briefly, the brachial plexus is formed by the anterior primary divisions of the lower four cervical and first thoracic nerves; these nerves pass to the axilla in between the scalenus anterior and the medius muscles and, at the upper end of the first rib, the trunks are formed. The upper trunk is formed by union of the fifth and sixth cervical nerves; the middle trunk by the seventh alone; the lower trunk by the eighth cervical and first thoracic nerves. The trunks separate into anterior and posterior divisions very shortly after crossing over the first rib. The cords are formed by combinations of the anterior and posterior divisions. The lateral cord is formed by the anterior division of the upper and middle trunks and lies lateral to the axillary artery. The medial cord is formed by the anterior division of the lower trunk and lies medial to the axillary artery. The posterior cord is composed of the posterior divisions of all three trunks and lies posterior to the axillary artery.

Submitted to the Publication Committee, September 25, 1968.

The Author

- **Walter D. Mazzacane, M. D., Chief, Anesthesiology Section, Veterans Administration Center, Martinsburg, West Virginia.**

The lateral cord gives rise to the lateral pectoral and musculocutaneous nerves and to the lateral head of the median nerve. The middle cord provides the origin of medial pectoral nerve, the middle cutaneous nerve of the arm and forearm and the ulner and medial heads of the median nerve. The posterior cord terminates as the radial nerve after giving rise to the subscapular nerves, the nerve to the latissimus dorsi and the axillary, or circumflex, nerve.

In the lower axilla, the course of the brachial plexus has already given rise to the terminal nerves of the arm and forearm. It is in this area that axillary brachial plexus block is performed; the procedure is known also as perivascular axillary brachial block.

Preoperative Procedure.—Preoperative evaluation of the patient is carried out and includes a complete history and physical examination, with complete blood count, blood chemistry, chest x-ray and ECG. Urinalysis and hematocrit must have been done within forty-eight hours of surgery or manipulation. The patient is carefully interrogated as to any drug allergies or idiosyncrasies. The axillary area is shaved clean, as is the upper arm. Then the area is scrubbed with phisohex solution, dried, and then painted with Tincture of Zephiran.

Preoperative medication consists of a barbiturate 50 to 75 mg. at bedtime and this same dose is administered two hours before surgery; Demerol 50 to 75 mg., Atarax 50 to 75 mg. and

Atropine Sulfate 0.4 mg. are given intramuscularly one hour before surgery. All of our patients are given an s.s. enema and are kept N.P.O. from midnight preceding surgery.

Technique of Brachial Plexus Block via the Axillary Route.—Here at the Veterans Administration Center in Martinsburg, West Virginia, the two-needle modified technique is used. The patient is placed on the operating table in the supine position with knee strap fixed, the arm abducted 90 degrees and the hand fully supinated. The axilla is painted with Tincture of Zephiran and draped with sterile towels. The axillary artery is localized by digital palpation, a 26 gauge needle is placed below it and a similar needle is placed above. When the needles are properly placed they will pulsate along with the axillary artery. The lower border of the pectoralis major muscle is the best landmark. The anesthetic solution is then prepared by mixing 30 cc's of Carbocaine Hydrochloride and 150 units of Wydase. Carbocaine Hydrochloride 1 per cent with Wydase 150 units has been used exclusively in our series of cases. Fifteen cc's. of the solution is injected above the axillary artery and 15 cc's. below the axillary artery. Repeated aspiration is done while slowly injecting the anesthetic solution so as to avoid injection into a blood vessel of the axilla. As with other anesthetic solutions, the usual precautions are observed and injection is immediately terminated if symptoms of intolerance are noted.

We have used this technique and the same anesthetic solution in 137 cases during the period from February 9, 1964 to August 19, 1968 in the treatment of fractures and other orthopedic conditions of the upper extremity without a single failure. The vital signs of each and every patient were monitored, the findings being recorded every five minutes.

Axillary brachial plexus block using the described technique provides sufficient time to complete surgery or manipulation of the upper extremity, with an average time of one hour and forty-five minutes to two hours. When a tourniquet is to be applied to the midportion of the humerus, a ring block is done using the same anesthetic solution. In our series of cases, there was no evidence of tourniquet pain when this was done.

Postoperative Care.—It was not found necessary to give pain relieving drugs for at least six hours following administration of axillary brachial plexus block. In most instances the patient became ambulatory immediately following surgery.

Complications.—There were no complications nor was there any evidence of tissue damage or irritation in any of the cases in our series.

Carbocaine Hydrochloride was used because of the fact that it has from two to two and one-half the anesthetic potency of Procaine. Its toxicity is from one and one-half to two times that of Procaine, hence it appears to have at least an equally favorable therapeutic index.

Mild side-effects consisting of nausea and vomiting were encountered in two of our cases and were quickly corrected by injecting 10 mg. of Compazine intravenously. If, however, circulatory or respiratory complications or any other toxic symptoms should manifest themselves, treatment should be instituted immediately.

Venoclysis of five per cent glucose in water is always started before the operative procedure is begun so as to have an accessible vein for any emergency that might arise.

Contraindications.—The presence of chronic or acute infection in the axilla contraindicates the use of axillary brachial plexus block. This is true also in the case of tumor masses which may distort the landmarks. We have found it extremely difficult to perform the block in the cases of patients who are physically unsuited, e.g., hemiplegics with adduction of the shoulder.

Indications for Use.—Axillary brachial plexus block is indicated in fractures of the upper extremity below the distal third of the humerus, also in other orthopedic conditions such as olecranon bursa. Other indications for this procedure are in cases in which general anesthesia is contraindicated because of the poor condition of the patient or in which general anesthesia is refused.

Still another indication for axillary brachial plexus block is in the treatment of burns and the changing of dressings below the distal third of the humerus.

Advantages.—Because of the simpler technique, complete avoidance of pneumothorax, Horner's Syndrome and painful paresthesias, it is our opinion that axillary brachial plexus block is safer for the patient.

Orthopedic Procedures

Revision tendon transplant of the wrist	1
Radial styloidectomy	1
Exploration thenar space	2
Excision supracondylar process of humerus	1
Bennett fracture of left thumb, reduction and fixation	1
P I P disarticulation	3
Phalengectomy	3
Transplant ulnar nerve	4
Reconstruction of rheumatoid hand	7
Excision of radial head	3
Neurolysis of ulnar nerve	2

Excision of ulcer in the antecubital fossa	1
Release of Dupuytren's contracture	31
Closed reduction of Colles fracture	14
Incision and drainage abscess of hand	3
Excision ganglion of wrist	10
Revision of amputation of fifth metacarpal bone	1
Excision of lipoma of palmar surface of hand	1
Excision of lunate bone	1
Transplant flexor carpi	1
Amputation of finger	5
Synovectomy, wrist	7
Repair tendons of fingers	5
Excision sebaceous cyst of hand	1
Excision of olecranon bursa	19
Littler's procedure	1
Decompression of wrist, ulnar and radius	2
Excision of foreign body of wrist	1
Revision of amputation of fingers	1
Debridement and suture of laceration of elbow	1
Excision of foreign body, elbow	1
Closed reduction of dislocated elbow, application of cast	1
Insertion of Rush nail for fracture of radius	1
Total cases	137

Summary and Conclusions

Axillary brachial plexus block is discussed in this review covering a total of 137 cases in which a variety of orthopedic procedures was performed without a single failure.

Carbocaine Hydrochloride 1 per cent with Wydase 150 units was used exclusively in the series.

In two cases, there were side-effects of nausea and vomiting which were quickly corrected by the administration of 10 mg. of Compazine in the intravenous tubing.

Axillary brachial plexus block is indicated in cases in which a general anesthetic is contraindicated and in acute emergencies such as "off the street" patients with a full stomach who have sustained injury, burns or fracture of the upper extremity.

The simplicity of the technique of performing axillary brachial plexus block, the greater margin of safety to the patient, the avoidance of complications such as pneumothorax, Horner's Syndrome, the pain of paresthesias and the ever present hazards of general anesthesia certainly make this the procedure of choice for surgery and manipulation of the upper extremity below the distal third of the humerus.

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To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal*. *The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual and immediate attention.

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Electrocardiogram of the Month

Benign A-V Dissociation

Edward K. Chung, M. D.

For many years, confusion has existed regarding the precise definition of atrioventricular (AV) dissociation. Characteristic of the confusion is whether or not complete AV block should be included in complete AV dissociation. However, the term "complete AV dissociation" has more clarity than that of "incomplete AV dissociation", which has been alluded to as "interference dissociation," "dissociation with interference," and "AV dissociation with captured beats."

The purpose of this paper is to present a case with a benign A-V dissociation.

The Author

- **Edward K. Chung, M. D., Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratories, West Virginia University, Morgantown.**

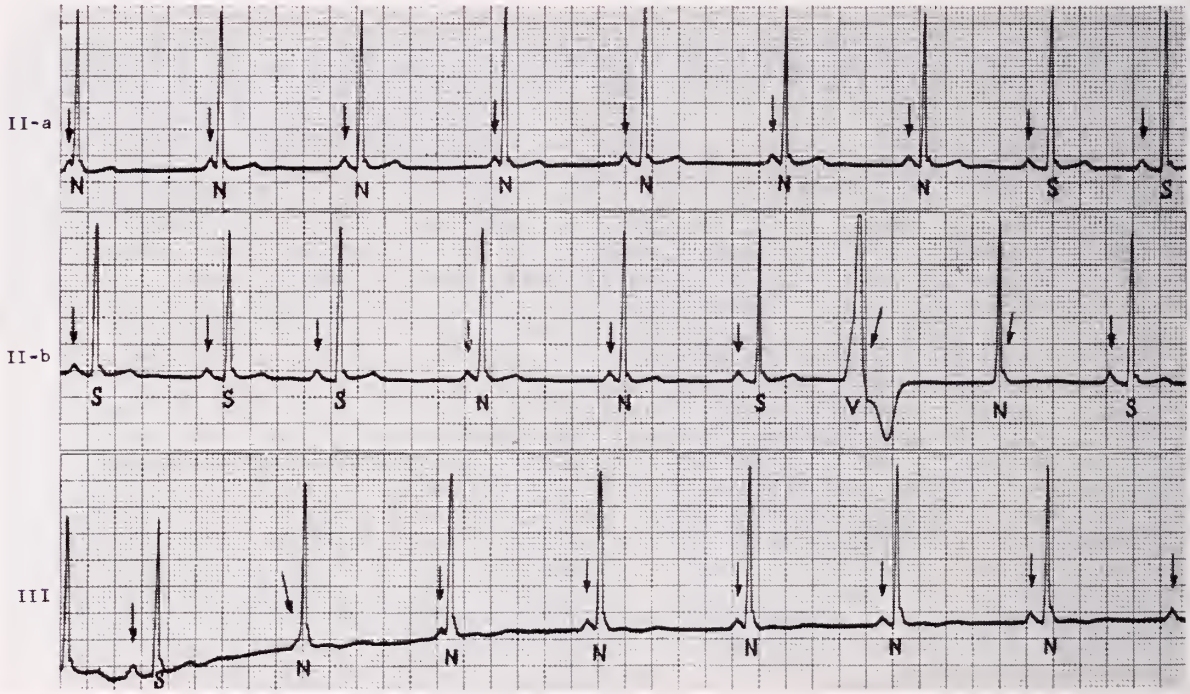

Figure 1

Electrocardiographic Analysis

Figure 1 was obtained from a 17-year-old Negro male who failed to show any evidence of heart disease. In Figure 1, leads II-a and b are not continuous. Arrows indicate P waves of sinus origin. This tracing shows sinus bradycardia and sinus arrhythmia (rate: 57-62/min) (marked N) producing incomplete A-V dissociation. S indicates normally conducted sinus beat. There is a ventricular premature contraction in lead II-b (marked V). The basic disorder for the development of A-V dissociation with intermittent A-V nodal escape rhythm in this tracing is a slowing of sinus impulse formation.

Discussion

By definition, AV dissociation indicates that the atria and ventricles beat independently, so that P waves and QRS complexes do not have

a constant relationship on the electrocardiogram.[1-6] Several basic disorders produce AV dissociation, and they will be discussed in this report.

(1) *Slowing of primary pacemaker.* The inherent rate of the primary pacemaker (sinus node) is 60 to 100 per minute in normal adults, while the AV node is 45 to 55 and the ventricles, 30 to 40.[6, 7] Whenever the primary pacemaker produces an impulse that is slower than usual, the AV node or ventricles may take over producing AV nodal escape or idioventricular rhythm, respectively. Almost always, AV nodal escape rhythm appears in this situation because of the faster inherent rate in the AV node, as compared with the ventricles. The atria and ventricles beat independently but at a similar rate (Figure 1). This type of AV dissociation may be observed in healthy young adults without any heart disease; however, it may be seen during digitalization. It has little clinical significance.

(2) *Acceleration of ectopic pacemaker in AV node or ventricles.* In this instance, the sinus node produces cardiac impulses as usual, but the AV node or ventricles initiate impulses faster, resulting in AV dissociation. Rapid ectopic pacemaker action may appear on the electrocardiogram as a paroxysmal or nonparoxysmal tachycardia. Paroxysmal AV nodal tachycardia may occur in healthy individuals and has almost the same clinical significance as sinus tachycardia. Nonparoxysmal AV nodal tachycardia is almost always found in heart disease, such as acute rheumatic carditis, acute diaphragmatic myocardial infarction, or digitalis intoxication.[7, 8]

(3) *Complete AV block or sinoatrial (SA) block or both.* Whenever the sinus impulse is not conducted to the AV node and ventricles due to a block either in the SA or AV juctional tissue or the common bundle or bilateral bundle branches, AV nodal escape rhythm or idioventricular rhythm develops to control the ventricles as a physiologic mechanism.[6] In this instance, the atrial is faster than, and also independent of, the ventricular rate.

Often both AV and SA blocks develop in the same patient particularly, in acute diaphragmatic myocardial infarction and digitalis intoxication.

If the mechanism of AV dissociation is not complete AV block, whenever any chamber is in a nonrefractory state one of the two pacemakers may activate the entire heart. In other words, the sinus pacemaker which controls the atria may control the ventricles when they are not in a refractory phase; this is termed "ventricular captured beats". An ectopic pacemaker in either AV node or ventricles which controls the ventricles may activate the atria in retrograde fashion when they are not in a refractory phase; such a phenomenon is termed "atrial captured beats". Whenever there is a captured beat, this should be termed "incomplete AV dissociation" because the atria and ventricles have some relationship, even though momentarily. If there is no captured beat and the atria and ventricles beat independently throughout, this should be called "complete AV dissociation."

Summary

A case with a benign AV dissociation is presented. AV dissociation is not a primary disturbance of cardiac rhythm and is always a result of some other basic disorders. It should be remembered that some AV dissociation such as herein reported is a benign arrhythmia which may be found in a healthy individual.

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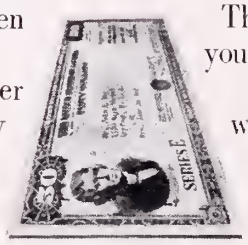

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A message from . . .

The President

A FEW THOUGHTS

FIRST I want to thank Mrs. John A. B. Holt, President of the Woman's Auxiliary to the West Virginia State Medical Association, for the excellent message in the March issue of *The Journal.*

Your President will be on the road the next three months. I hope I can convey some of the findings to the members of the Association.

In February I had a most enjoyable visit at the West Virginia University Medical School at which time I talked with the students. I found, as our two previous speakers had, that they are interested in practice in West Virginia, both its pros and cons.

I am sure the members of the Association were gratified that the members of the House Finance Committee did not see fit to divert the "pop tax" revenue from the West Virginia University Medical Center. Your Association opposed transferring the tax from the Medical Center to the general revenue fund for obvious reasons.

Richard W. Corbitt MD,

RICHARD W. CORBITT, M. D., *President*

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EDITORIAL

REGRESSION OF CARDIAC HYPERTROPHY

A significantly hypertrophied heart is regarded as a serious matter. Cardiac hypertrophy may be caused by many conditions; these, however, will not be enumerated in this short essay. Unfortunately, in many instances once the heart has hypertrophied it will remain so indefinitely. What is not often appreciated is that there may be a noticeable regression of cardiac hypertrophy if the initial cause of the hypertrophy is removed; indeed, the heart may even return to its normal size.

As early as 1921 Dedichen[1] reported regression of cardiac hyperthrophy which was said to have been caused by severe physical exertion. Master,[2] also working with human beings, observed that following strenuous bodily activity the heart returns to normal size. In these instances it may be, of course, that these observers were working with a dilated heart rather than an hypertrophied heart. In 1931 Matas and Heninger[3] reported regression of cardiac hypertrophy following the elimination of a congenital cavernous hemangioma in man. It is definitely known that individuals who have lived for a long time at high altitudes do develop a true cardiac hypertrophy. Rotta[4] has clearly shown that in such persons the heart in time will return to normal size with lowland residence.

Numerous instances may be found in the literature that experimental cardiac hypertrophy produced in animals, such as rats or dogs, may regress. For example, cardiac hypertrophy produced by severe exercise, or by constriction of the aorta, or by establishing experimental hypertension, or by administration of thyroxin, will disappear if the producers which produced the cardiac hypertrophy are eliminated.

If regression of cardiac hypertrophy occurs in human beings, or for that matter in lower animals, it is believed that the heart has not suffered permanent damage, and presumably longevity would not be affected. It might well be, however, that if the cardiac hypertrophy has been pronounced or has existed for a long time, the myocardium may have suffered irreparable damage. In this event, the patient in later life may experience difficulty. This matter needs further elucidation.

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GENERAL NEWS

General Blumberg and Dr. Jackman To Speak at Annual Meeting

The highest ranking pathologist in the United States Armed Forces and a prominent colon and rectal surgeon have accepted invitations to appear as guest speakers at the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.

Raymond J. Jackman, M. D.

Maj. Gen. Joe M. Blumberg (MC)

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Maj. Gen. Joe M. Blumberg of Washington, D. C., and Dr. Raymond J. Jackman of Rochester, Minnesota, will present papers during the three-day meeting.

Maj. Gen. Joe M. Blumberg (MC)

General Blumberg, Commanding General of the United States Army Medical Research and Development Command, will appear as a guest speaker at the first general scientific session on Thursday morning, August 21.

A native of Atlanta, Georgia, General Blumberg received his M. D. degree in 1933 from Emory University School of Medicine. He interned at Maryland General Hospital in Baltimore and served a residency at Baltimore City Hospital. He practiced medicine and pathology in Baltimore from 1936 to 1941.

He was commissioned in the United States Army Medical Corps Reserve in 1935 and was called to active duty in 1941. Some of his principal assignments included duty as Chief of the Laboratory Service at the Walter Reed Army Hospital, Commanding Officer and Chief of Pathology of the 406th Medical General Laboratory in Japan, and Consultant in Pathology and Laboratory Medicine to the Chief Surgeon of the Armed Forces in the Far East. Prior to being named to his present position in 1967, he served as Director of the Armed Forces Institute of Pathology.

General Blumberg is certified by the American Board of Pathology in anatomic pathology, clinical pathology and forensic pathology. He is a member of the American Society of Clinical Pathologists and the Southern Medical Association. He is currently serving as a member of the Board of Governors of the College of American Pathologists.

Raymond J. Jackman, M. D.

Dr. Raymond J. Jackman, Senior Consultant of the Section of Proctology at the Mayo Clinic in Rochester, Minnesota, will appear as a guest speaker at the second general scientific session on Friday morning, August 22. His subect will be "Crohn's Disease."

A native of Emmetsburg, Iowa, Doctor Jackman received his M. D. degree in 1930 from the University of Iowa School of Medicine. He interned at St. Mary's Hospital in Kansas City, Missouri, and served as a Fellow in Proctology at the Mayo Foundation. He received a Master of Science degree in 1938 from the University of Minnesota School of Medicine.

Doctor Jackman also serves as Professor of Proctology at the Mayo Graduate School of Medicine of the University of Minnesota School of Medicine. He is a member of the American Medical Association and is currently serving as President of the Minnesota State Board of Health.

Scientific Program Nearly Completed

Doctor Stark announced that arrangements have nearly been completed for the scientific program which will be presented during the three-day meeting. The other members of the Program Committee are Drs. A. B. Curry Ellison and Seigle W. Parks of Charleston, I. Ewen Taylor of Huntington and Herbert E. Warden of Morgantown.

It was announced previously that Dr. Gerald D. Dorman of New York City, President Elect of the American Medical Association, had accepted an invitation to appear as a guest speaker at the first session of the Association's House of Delegates on Wednesday afternoon, August 20. Doctor Dorman will be installed as President of the AMA at the Annual Convention in July.

Another honor guest will be Gov. Arch A. Moore, Jr., who has accepted an invitation to appear as a guest speaker at the first general scientific session on Thursday morning, August 21.

Doctor Stark said that members of the Auxiliary and other guests attending the meeting at The Greenbrier

are cordially invited to listen to the addresses by Governor Moore and Doctor Dorman.

It also was announced previously that the following two physicians had accepted invitations to appear as guest speakers:

Dr. Emanuel M. Papper of New York City, Professor and Chairman of the Department of Anesthesiology at the College of Physicians and Surgeons of Columbia University.

Dr. Kermit E. Krantz, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will appear in the Convention Number in August.

Adolescent Medicine Course At GW Medical Center

A postgraduate course entitled "Recent Advances in Adolescent Medicine" will be held in Washington, D. C., May 21-23.

The course is sponsored by the American Academy of Pediatrics in cooperation with the George Washington University Medical Center. The sessions will be held at the Children's Hospital of the District of Columbia.

A distinguished guest faculty will join the Children's Hospital staff in presenting this program.

Registration will be limited to 100 persons, and there will be a registration fee of $5.00. In addition, there will be a tuition fee of $75 for members of the Academy and $105 for nonmembers.

Additional information may be obtained by writing to Dr. Gerald E. Hughes, Secretary for Educational affairs, American Academy of Pediatrics, P. O. Box 1034, Evanston, Illinois 60204.

Otolaryngology Division Lists PG Course

The Division of Otolaryngology at the West Virginia University Medical Center will sponsor a postgraduate course at the Medical Center, May 15-17.

Title for the three-day seminar is "Otolaryngology for the Primary Physician." The course will stress the early diagnosis and treatment of ear, nose and throat diseases with particular reference to multidisciplanary approach. Application has been made to the American Academy of General Practice for 18 hours of credit.

Registration will begin at 8 A. M. on May 15 in the main auditorium of the Medical Center. A registration fee of $10 will be charged.

Additional details of the meeting will be published in the May issue of *The Journal*.

Detailed information may be obtained by writing to: Dr. Fred D. Owens, Division of Otolaryngology, West Virginia University Medical Center, Morgantown.

Dr. Denton Cooley To Address Maryland Medical

Dr. Denton A. Cooley, internationally known heart surgeon at the Baylor University School of Medicine, will be among the featured scientific speakers at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland this month.

The sessions will be held April 9-11 at The Alcazar in Baltimore.

Doctor Cooley will speak on Thursday afternoon, April 10, and his subject will be "Experiences with Cardiac Transplantation in Man."

Other features of the scientific program will include a Coronary Care Panel on Friday morning, April 11.

Additional information about the meeting may be obtained by contacting the Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

Looking Back 10 Years . . .

Two members of the State Medical Association are shown in conversation with Kenneth E. Penrod, Ph.D. (right) during the Annual Meeting of 1959. Doctor Penrod was Vice President of the West Virginia University Medical Center at the time. Others in the picture are: Dr. J. P. McMullen of Wellsburg (left) and Dr. Frank J. Holroyd of Princeton.

Governor Moore To Be Honor Guest At 102nd Annual Meeting

Gov. Arch A. Moore, Jr., will be among the honor guests at the 102nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23.

Gov. Arch A. Moore, Jr.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Governor Moore had accepted an invitation to appear as a guest speaker at the first general session on Thursday morning, August 21. His address will follow opening remarks by Doctor Stark and Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association. His subject will be announced at a later date.

Governor Moore was born in Moundsville and educated in the public schools of Marshall County. He was graduated from West Virginia University and received his Bachelor of Law (LL.B.) degree in 1951.

During World War II, Governor Moore served as a Combat Sergeant in the United States Army. He was the recipient of the Purple Heart as the result of severe wounds received on the battlefield.

Governor Moore was elected to the West Virginia House of Delegates in 1952 and in 1956 he was elected to the first of six consecutive terms in the United States Congress. During his service in Congress he became a ranking Republican member of the House Judiciary Committee and several other influential committees.

He is presently Republican National Committeeman from West Virginia and served as Chairman of the Sub-Committee in Charge of Rules and Procedures of the 1968 Republican National Convention.

He was elected the 28th Governor of West Virginia on November 5, 1968, and was inaugurated an January 15, 1969. He is married to the former Shelley Riley and they have three children.

HOPE Makes Return Voyage To United States

The hospital ship S. S. HOPE returned to the United States on March 22, completing a year-long voyage to the island nation of Ceylon.

When the ship arrived in Philadelphia, it was greeted by hundreds of well-wishers and families of the volunteer physicians, dentists, nurses and technologists.

Following debarkation of the medical staff, the ship will enter a period of repair and resupply in preparation for the next sailing in September.

HOPE'S mission to Ceylon was the most comprehensive ever undertaken by the ship. The permanent staff of 135 U. S. medical specialists, supplemented during the course of the voyage by 180 volunteer physicians and dentists, conducted educational exchange programs with more than 1,150 Ceylonese medical and paramedical counterparts on the ship, and in hospitals, schools and clinics throughout the country.

In Ceylon the HOPE medical staff treated more than 1,700 patients aboard ship and, with Ceylonese counterparts, conducted some 2,280 operations. More than 3,000 patients were treated in the ship's dental department, and some 70,000 children received immunization against diphtheria, whooping cough and tetanus.

Ceylon is the eighth nation visited by the S. S. HOPE. Beginning with her maiden voyage in 1960, the ship has conducted medical teaching missions to Indonesia, Vietnam, Guinea, Peru, Ecuador, Nicaragua and Colombia. Teaching programs continue in the latter four of these countries.

Founded in 1958 by Dr. William B. Walsh, Project HOPE is the principal activity of The People-to-People Health Foundation, Inc. of Washington, D. C., an independent, non-profit corporation supported by American individuals and industry.

Doctor Walsh was an honor guest at the Annual Meeting of the West Virginia State Medical Association in 1967.

College of Physicians Lists Three May Courses

The American College of Physicians will sponsor three postgraduate courses in May. They are as follows.

May 12-16—"Internal Medicine—The Good That's Old; The New That's Vital"—Temple University School of Medicine, Philadelphia.

May 19-22—"Adolescent Medicine"—University of Washington School of Medicine, Seattle.

May 19-23—"Intensive Care Units"—New York University and St. Vincent's Hospital, New York City.

Fees for each course are $60 for members of the ACP and $100 for non-members. Additional information may be obtained by writing to American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Arthritis and Rheumatism Seminars Scheduled

Programs on arthritis and rheumatism will be held in Kentucky and Virginia during the months of April and May.

An Arthritis Seminar will be held at the Hotel Roanoke in Roanoke, Virginia, May 9-10, under the sponsorship of the Roanoke Branch of the Arthritis Foundation. Meanwhile, the Kentucky Chapter of the Arthritis Foundation and the University of Louisville School of Medicine are sponsoring a Symposium on Rheumatic Diseases in Louisville on April 10.

Daniel Hamaty, M. D.

Dr. Daniel Hamaty of Charleston will participate in the Virginia meeting. Doctor Hamaty will moderate the session on the afternoon of Friday, May 9.

Information about these meetings may be obtained by contacting: Mrs. Anna K. Updike, Executive Secretary, Roanoke Branch, The Arthritis Foundation, Roanoke Memorial Rehabilitation Center, Roanoke, Virginia 24014; and Mr. Louis M. Baugh, Executive Director, Kentucky Chapter, The Arthritis Foundation, 209 Speed Building, Louisville, Kentucky 40202.

Breast Cancer Conference In Washington

The National Conference on Breast Cancer will be held at the Shoreham Hotel in Washington, D. C., May 8-10.

Sponsors are the American Cancer Society and the Cancer Control Program of the U. S. Public Health Service.

The program on May 8 will be devoted to epidemiology, causation and pathogenesis; and current control measures and their effectiveness. Changing concepts in detection and diagnosis; and research, resources and possible developments for the control of breast cancer will be explored the following day. Discussion topics for the final day of the three-day meeting will include management of operable and inoperable cases.

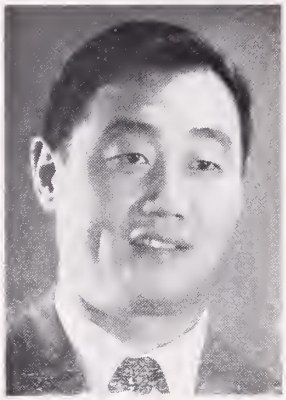
Additional information may be obtained by writing to Dr. R. N. Grant, National Conference on Breast Cancer, American Cancer Society, 219 East 42nd Street, New York City, New York 10017.

College Installs Dr. Poole

Dr. Thomas R. Poole of Charleston will be installed as a Fellow of the American College of Obstetricians and Gynecologists at the College's Annual Meeting, which begins April 28 in Bal Harbour, Florida.

College of Radiology Honors Two State Physicians

Two West Virginia physicians were among 119 radiologists who were made Fellows of the American College of Radiology at the Annual Meeting of the College in Atlanta, Georgia, on February 21.



C. H. Joseph Chang, M. D.

J. Dennis Kugel, M. D.

They are Dr. C. H. Joseph Chang of Morgantown, Associate Professor of Radiology at the West Virginia Medical Center, and Dr. J. Dennis Kugel of Charleston. Both men are members of the West Virginia State Medical Association.

Doctor Chang received his M. D. degree from Severance Medical College in Seoul, Korea; interned at St. Joseph's Hospital in Phoenix, Arizona; and served a residency in radiology at Emory University Hospital in Atlanta. He is a Diplomate of the American Board of Radiology.

Doctor Kugel received his M. D. degree from Northwestern University Medical School, interned at Passavant Memorial Hospital in Chicago and served a residency at Augustana Hospital, also in Chicago. He also is certified by the American Board of Radiology.

MLB Licenses Six Physicians To Practice in State

The Medical Licensing Board licensed six physicians to practice medicine in West Virginia during meetings of the MLB in Charleston in December and January.

At a meeting in Charleston on December 10-12, the Board licensed the following physician by direct examination (FLEX):

Christian, Martha Haltom, Morgantown

The MLB licensed the following five physicians by reciprocity at a Board meeting held at The Capitol in Charleston on January 6, 1969:

Eckert, Herbert Lewis, Morgantown
Fiscus, Wilbur Guy, Parsons
Harper, Larry Olen, Morgantown
Modlin, Robert Kent, Washington, D. C.
Pfister, Alfred Karl, Charleston

The next meeting of the Medical Licensing Board will be held at The Capitol in Charleston on April 7, 1969, for the purpose of licensing by direct examination and reciprocity.

State Pediatricians Prepare For Spring Meeting

Speakers from both medicine and dentistry will participate in the Annual Spring Meeting of the West Virginia Chapter, American Academy of Pediatrics, in Princeton this month.

Mabel Stevenson, M. D.

The sessions will be held Thursday and Friday, April 10-11. Dr. Forest A. Cornwell of Beckley, Chairman of the Chapter, will preside at a Chapter business meeting on Thursday morning and also will serve as Moderator for the First Scientific Session that afternoon.

Dr. Meryleen B. Smith of Peterstown, Program Chairman, said the program will present new and important aspects to be considered in the overall management of the pediatric patient.

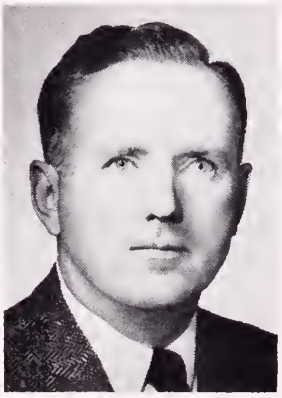
The American Academy of General Practice has approved the scientific program for nine prescribed hours of credit for its members.

Physicians, dentists and others who will present papers during the meeting are as follows:

Jacqueline Noonan, M. D., Associate Professor of Pediatrics, University of Kentucky College of Medicine, Lexington; Stanley Poleway, D. D. S., Charleston; H. E. Kiser, Jr., D. D. S., Bluefield; and W. E. Copenhaver, M. D., Department of Radiology, St. Luke's Hospital, Bluefield.

Steven J. Ruma, Ph. D., Assistant Professor of Pediatrics and Psychology and Director of Psychology Education, Children's Hospital, Ohio State University College of Medicine, Columbus; John Kelley, M. D., Departments of Psychiatry and Pediatrics, West Virginia University Medical Center.

John P. Utz, M. D., Professor of Medicine, Medical College of Virginia, Richmond; Mabel Stevenson, M. D., Department of Clinical Pathology, WVU Medical Center; and Herbert E. Eckert, M. D., Associate Professor of Preventive Medicine and Pediatrics, WVU Medical Center.



John P. Utz, M. D.

John Kelley, M. D.

Titles of all papers to be presented were listed in the March issue of *The Journal.*

A social hour and banquet will be held on Thursday evening. Mr. Rex M. Smith, State School Superintendent, will be the after-dinner speaker.

Additional information about the meeting may be obtained by contacting: Dr. Meryleen B. Smith, Box 356, Peterstown, West Virginia.

Coronary Care Conference In Denver in June

The National Conference on Coronary Care Units will be held at the Denver Hilton Hotel in Denver, Colorado, June 18-20.

Theme for the meeting, sponsored by the American Heart Association, is "Drug Therapy in Coronary Care—1969." The meeting has been arranged as a forum for physicians and nurses who work in coronary care units.

Included in the three-day program will be discussions of teaching methods for physicians and nurses. Medical experts from throughout the nation will speak on such subjects as "Coronary Care Unit: A New Generation," "Philosophy of Drug Management in Acute Myocardial Infarction," "Mechanism of Action of Anti-Arrhythmic Agents," "Clinical Pharmacology of Anti-Arrhythmic Agents," "Problems in Drug Interaction," and others.

Registration fee for the conference is $40. Registration forms may be obtained from William D. Nelligan, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

Cleveland Clinic Foundation Lists Final Courses

Two postgraduate courses, one in April and one in May, will bring the Cleveland Clinic Educational Foundation's 1968-69 schedule to a close.

The Foundation will conduct a "Symposium on Rheumatic Disease," April 16-17. Scheduled for May 8-9 is a "Postgraduate Course in Diet Therapy."

Additional information may be obtained by writing to: Director of Education, Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

University of Virginia Lists April PG Course

A postgraduate course entitled "Psychological Adaptation to Catastrophic Events" will be held at the University of Virginia School of Medicine in Charlottesville, April 23-24.

Additional information about the program may be obtained by writing to: Continuing Education Program, Dean's Office, Medical School, University of Virginia, Charlottesville, Virginia 22901.

American College of Surgeons Names New Director

The Board of Regents of the American College of Surgeons has announced the selection of Dr. C. Rollins Hanlon of St. Louis, Missouri, as Director Elect of the College.

Doctor Hanlon will assume the directorship of the College after the close of the 1969 Clinical Congress in San Francisco, October 6-10. He will succeed Dr. John Paul North, who informed the Board two years ago of his intention to retire in 1969. He has been Director of the ACS since 1961.

Doctor Hanlon presently is Professor of Surgery and Chairman of the Department of Surgery at the St. Louis University School of Medicine. He will be the fifth Director in the 56-year history of the ACS, which now has more than 30,000 Fellows in the United States, Canada and about 90 other countries.

3,000 Doctors to Attend Ob.-Gyn. Meeting

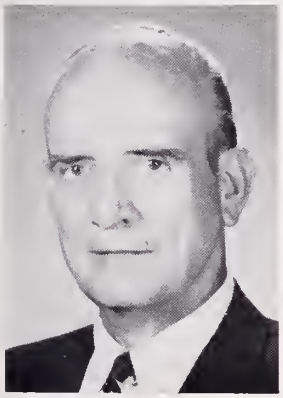
About 3,000 physicians are expected to attend the 17th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, which will be held at the Americana Hotel in Bal Harbour, Florida, April 28 to May 1.

The scientific program will be presented by some 500 nationally prominent physicians, most of them Fellows of the College.

Programs and other information about the meeting may be obtained by writing to: Meeting Services Department, American College of Obstetricians and Gynecologists, 79 West Monroe, Chicago, Illinois 60603.

Mr. J. Banks Shepherd Heads Insurance Group

Mr. J. Banks Shepherd of Charleston has been elected President of the American Institute of Professional Association Group Insurance Administrators.



J. Banks Shepherd

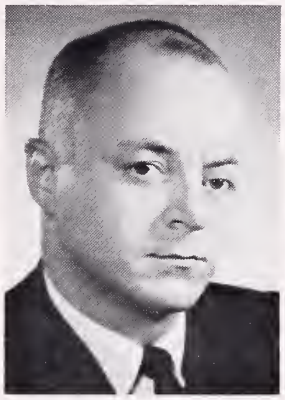
The election of Mr. Shepherd, President of the insurance firm of McDonough-Caperton-Shepherd-Goldsmith, came at the mid-winter conference of the Institute on Grand Bahama Island on March 9. Mr. Shepherd is Administrator of the insurance program sponsored by the West Virginia State Medical Association.

McDonough - Caperton - Shepherd - Goldsmith pioneered in the writing of association group insurance and have established an outstanding record of performance in this highly specialized field, according to an announcement from the Institute.

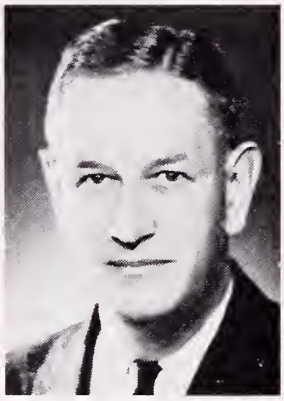
ACS Director To Be Guest Of State Chapter

The Annual Meeting of the West Virginia Chapter of The American College of Surgeons will be held at The Greenbrier in White Sulphur Springs, April 17-19.

The Chapter's Council will meet on Wednesday evening, April 16, and the Chapter business meeting will be conducted on the morning of April 19. Scientific sessions will be held each day from 9 a. m. to noon, and afternoons will be left free for recreation.



George E. Block, M. D.



John Paul North, M. D.

Guest speakers will include Dr. John Paul North, of Chicago, Director of the American College of Surgeons; and Dr. George E. Block, Professor of Surgery at the University of Chicago School of Medicine.

Doctor North, Director of the College for the past eight years, will address the Chapter on Saturday, April 19. He is a native of Buffalo, New York, and received his M.D. degree from the University of Pennsylvania in 1926.

Doctor Block will be the principal scientific speaker. He is Coordinator of Education in Clinical Oncology and Head of the Section of Head and Neck Surgery, University of Chicago. He was born in Joliet, Illinois and received his M. D. degree from the University of Michigan School of Medicine in 1951.

Dr. Richard A Currie of Morgantown is President of the West Virginia Chapter. Dr. John W. Trenton of Kingwood is Vice President, and Dr. Herbert G. Dickie of Wheeling is Secretary-Treasurer.

Dr. Jack Morgan Is Appointed Hospital Chief

Gov. Arch A. Moore, Jr., has appointed Dr. Jack C. Morgan of Fairmont as Superintendent of Fairmont Emergency Hospital.

Doctor Morgan succeeds Dr. Philip Johnson, who retired after eight years in the post. Doctor Morgan will continue his private surgical practice.

He is a member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association. He is also a Fellow of the American College of Surgeons and a Diplomate of the American Board of Surgery.

Syphilis Vaccine Is Possible, Dermatologist Says

A recent issue of the "State of the State's Health" said that on May 30, 1968, directors of the American Social Hygiene Association and their guests were told that there is "a good possibility" of developing soon a vaccine to knock out syphilis. These comments were made by Dr. John M. Knox, Professor of Dermatology at Baylor University College of Medicine.

In 1966, the John A. Hartford Foundation provided a grant in the amount of $272,808 to support a three-year study for development of a vaccine against syphilis. Doctor Knox and a six-man Baylor medical team began the research which resulted in his optimistic view mentioned above. Doctor Knox believes other laboratories should become active in the search for an effective syphilis vaccine.

State Health Director N. H. Dyer noted that researchers at the National Communicable Disease Center in Atlanta, Georgia, report that experiments being conducted with apes infected with Pinta, a chronic skin disease found in certain parts of tropical America, may help protect mankind from the age-old scourge of syphilis. The germ which causes Pinta cannot be distinguished in the laboratory from the germ which causes syphilis. At the time of this report, infections have been noted in four of six laboratory apes exposed to Pinta. These experiments marked the first time that Pinta germs have been established in animals.

These researchers hope to use Pinta against syphilis much as the mild disease cowpox is used against smallpox. Persons immunized with vaccine derived from cowpox germs produced antibodies which protect them against the related but far more serious disease smallpox. Researchers believe Pinta antibodies will similarly prevent syphilis.

A syphilis vaccine, Doctor Dyer said, would certainly be a milestone for the syphilis control program but it would by no means insure the eradication of this disease. There are many persons who fail to realize that syphilis strikes without regard to age, race, or social status. Therefore, many prospective victims of syphilis would not present themselves nor their children for vaccination.

Also in a recent issue of the "State of the State's Health," Doctor Dyer pointed out a report from the National Venereal Disease Program in Atlanta, in view of the fact that the congenital syphilis case rate in West Virginia ranks sixth in the United States. The report, entitled "A Specific IgM Antibody Test in Neonatal Congenital Syphilis" appeared in the *Journal of Pediatrics*, St. Louis, Vol. 73, No. 2, August, 1968.

The article relates that diagnosis of congenital syphilis in the newborn is not difficult when there are darkfield-positive lesions or other conclusive clinical evidence. However, the diagnosis is very difficult when a clinically normal infant has a reactive serology. In such cases the clinician must decide whether the reactive serology is caused by a passive transfer of antibodies from the mother or is the result of an active syphilis infection.

The report states that "An experimental indirect fluorescent antibody test for demonstrating IgM syphilitic antibody was performed on sera from newborn infants with proved or suspected congenital syphilis. The test was reactive in all three cases of proved syphilis and was nonreactive in all 10 cases of clinically negative infants with reactive VDRL and FTA-ABS tests. Six clearly nonsyphilitic infants were nonreactive in all tests."

The preliminary results of the study indicate that this test may be specific for congenital syphilis in the newborn and that it is nonreactive in the case of passive transfer of a maternal syphilitic antibody.

The study was a preliminary report to demonstrate the feasibility of such a test and to stimulate a larger controlled study to fully evaluate and standardize procedures. The sensitivity of the new test could not be determined from the study.

An enlarged study is presently being conducted by the Venereal Disease Research Laboratory and specimens are needed to fully evaluate and standardize test procedures. Doctor Dyer urges clinicians to contact the West Virginia State Department of Health, Bureau of Venereal Disease Control, 1800 Washington Street, East, Charleston, West Virginia 25305, if they have a suspected case of neonatal congenital syphilis and would like to submit a specimen for inclusion in the study.

Hospital Patient Care Costs Jump 12.4 Per Cent

Expenses incurred by hospitals in providing one patient with one day of care in 1968 averaged $65.24, according to Hospital Indicators published last month in *Hospitals*, Journal of the American Hospital Association. This represents a 12.4 per cent increase over the 1967 average daily expenses of $58.06.

Hospitals in 1968 employed more people and paid them higher wages than ever before, AHA said. The average annual wage paid to hospital employees in 1968 was $5513, or $488 more than the $5025 paid in 1967.

As a result, payroll expenses per patient day increased by 12.9 per cent in 1968 over 1967—from $36.30 to $40.97. The number of employees on the payrolls increased by 6.8 per cent to 1.7 million persons. There are now 272 hospital workers for every 100 patients, while in 1967 there were 264 employees for every 100 patients.

While payroll is their biggest expense, hospitals also incur expenses for equipment, services, supplies, employee fringe benefits and other items. In 1968, total expenses for the nation's 5,850 community hospitals were $14.7 billion, or $2.1 billion more than in 1967.

The public continues to make more use of hospitals services and facilities and this is a factor in increased expenses, according to Hospital Indicators.

For the seventh straight year, the number of births in hospitals declined. The total for 1968 was 3.12 million, compared with 3.15 million in the previous year.

17th AAGP Scientific Assembly In Wheeling This Month

Gwendolyn Hogan, M. D.

O. Spurgeon English, M. D.

The 17th Annual Scientific Assembly of the West Virginia Chapter, American Academy of General Practice, will be held at Oglebay Park in Wheeling, Friday through Sunday, April 25-27.

The scientific program for Friday afternoon, April 25, will be sponsored by the West Virginia Division, American Cancer Society. Speakers and their topics will be as follows:

"Cancer in Childhood"—Judson Randolph, M. D., Pediatric Surgeon, Children's Hospital, Washington, D. C.

"Viruses in Cancer"—Robert Glen Ravdin, M. D., University of Pennsylvania School of Medicine, Philadelphia.

"Recent Advances in Cancer Research"—Seymour Perry, M. D., National Cancer Institute, Bethesda, Maryland.

Saturday Morning Program

The program for Saturday morning will be as follows:

"Management of Prolonged Labor"—Waldo Fielding, M. D., Assistant Professor of Obstetrics and Gynecology, Tufts Medical School, Boston.

"Bleeding of Pregnancy—Diagnosis and Treatment"—(Speaker to be announced).

"What Can or Cannot Be Done With The Obese Child or Adolescent"—Mary Daugela, M. D., Department of Adolescent Medicine, Children's Hospital, Washington, D. C.

"Brain Damage Syndromes"—Gwendolyn Hogan, M. D., Assistant Professor of Neurology and Pediatrics, West Virginia University School of Medicine, Morgantown.

Saturday Afternoon Program

The scientific program for Saturday afternoon will be as follows:

"Office Otology-Dizziness"—Ralph J. Caparosa, M. D., Pittsburgh Otological Association, Pittsburgh.

"Kidney Transplant"—William Kiser, M. D., Department of Urology, The Cleveland Clinic, Cleveland, Ohio.

"Present Status of Antibiotic Therapy"—Ray A. Van Ommen, M. D., Department of Infectious Diseases, The Cleveland Clinic, Cleveland, Ohio.

"Arrhythmias and Their Management"—James G. Clark, M. D., Presbyterian-St. Luke's Hospital, Chicago.

Sunday Morning Program

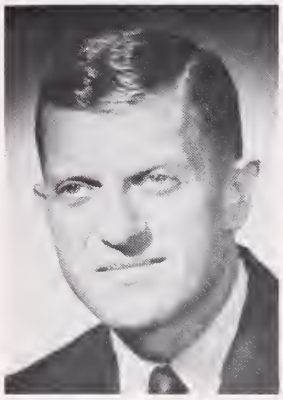
The final scientific session will be held on Sunday morning, April 27, with the following speakers and topics:

"Is Geriatrics Pounding at Your Door?"—C. Howard Ross, M. D., Ann Arbor, Michigan.

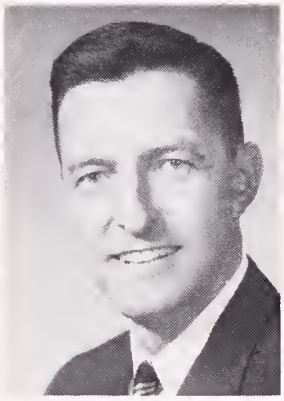
"Heart Attacks Need Not Happen"—Robert S. Green, M. D., Cincinnati, Ohio.

"Value of Radiology-Pathology Correlation"—Elias G. Theros, M. D., Armed Forces Institute of Pathology, Washington, D. C.

"What To Do With The Hippie In Your Practice"—O. Spurgeon English, M. D., Department of Psychiatry, Temple University Medical School, Philadelphia.



Seymour Perry, M. D.



Judson Randolph, M. D.

Officers of the West Virginia Chapter of the AAGP include: Dr. Del Roy Davis of Kingwood, President; Dr. C. Carl Tully of South Charleston, President Elect; Dr. James E. Spargo of Wheeling, Vice President; Dr. Everett B. Wray of Beckley, Secretary; and Dr. Joe N. Jarrett of Oak Hill, Treasurer.

Additional infomation about the meeting may be obtained by writing to Mr. Donley T. Shultz, 1008 Christie Street, Fairmont, West Virginia.

Bone and Joint Disease Course In Lexington, Ky.

A symposium on "Current Concepts in Bone and Joint Disease" will be held at the University of Kentucky Medical Center in Lexington, April 29 through May 2.

The course will be completed the day before the Kentucky Derby in Louisville.

The University of Kentucky Department of Radiology is presenting the course in cooperation with the Departments of Orthopedics and Pathology.

Subject matter will include the arthritides, trauma, and chondrodysplasias, among others.

Additional information may be obtained by writing to Dr. Harold D. Rosenbaum, Professor and Chairman, Department of Radiology, University of Kentucky Medical Center, Lexington, Kentucky 40506.

New Association Members

Dr. Bernardino D. Marcelo, 1090 Fairfax Street, Berkeley Springs (Eastern Panhandle). Doctor Marcelo, a native of the Philippines, received his M. D. degree in 1955 from Manila Central University. He interned at Manila Central University Hospital and served residencies in hospitals in New York and Ohio. He served as a house physician at Weirton General Hospital, 1961-65, and was formerly located in Fairmont. He is engaged in general practice.

* * * *

Dr. Josefina Q. Marcelo, 1090 Fairfax Street, Berkeley Springs (Eastern Panhandle). Doctor Marcelo, a native of the Philippines, received her M. D. degree in 1956 from the University of Santo Tomas. She interned at the University of Santo Tomas Hospital and served residencies at hospitals in Arizona, Pennsylvania and Ohio. She served as a house physician at Weirton General Hospital, 1961-65, and was formerly located in Fairmont. She is engaged in general practice.

* * * *

Dr. Pedro L. Siazon, Colin Anderson Center, St. Marys (Parkersburg Academy). Doctor Siazon, a native of the Philippines, received his M. D. degree in 1956 from the University of Santo Tomas. He interned at Walther Memorial Hospital in Chicago and served a residency at Hahnemann Medical College Hospital. He was previously located in the Philippines and his specialty is pediatrics.

* * * *

Dr. John F. Suess, Lost Creek (Harrison). Doctor Suess, a native of Pittsburgh, was graduated from the University of Pittsburgh and received his M. D. degree in 1943 from the University of Pittsburgh School of Medicine. He interned at St. Francis Hospital and served residencies at hospitals in Pennsylvania and Massachusetts. He served as a Commander in the Medical Corps of the United States Navy and his specialty is internal medicine.

* * * *

Dr. Terry T. Tallman, Fairmont Clinic, Fairmont (Marion). Doctor Tallman, a native of Alma (Tyler County), was graduated from West Virginia University and received his M. D. degree in 1963 from the WVU School of Medicine. He interned at WVU Hospital, 1963-64. He served as a Captain in the Medical Corps of the United States Air Force, 1964-66, and he is engaged in general practice.

* * * *

Dr. John C. Turner, Fairmont General Hospital, Fairmont (Marion). Doctor Turner, a native of Fair Bluff, North Carolina, was graduated from Duke University and received his M. D. degree in 1956 from the Duke University School of Medicine. He interned at Confederate Memorial Medical Center in Shreveport, Louisiana, and served residencies at Huey P. Long Charity Hospital in Pineville, Louisiana, and Walter Reed Army Hospital in Washington, D. C. He served as a Major in the Medical Corps of the United States Army, 1961-68, and his specialty is radiology.

HEW Official to Keynote Health Conference

Dr. Richard McGraw, Deputy Assistant Secretary of Health Manpower for the U. S. Department of Health, Education and Welfare, will keynote the Annual State Health Conference, which will be held at The Daniel Boone Hotel in Charleston, May 7-9.

The program is sponsored by the West Virginia Public Health Association and the State Department of Health.

Doctor McGraw will open the session on Thursday, May 8, with a discussion of "The National Scope of Innovation and Change in Health Matters."

The second Thursday morning speaker will be Dr. Jerome S. Beloff and/or Marion Willett, R.N., who will speak on "Our Experience with the Yale-New Haven Family Health Care Program." The third speaker, Lucy M. Cohen, Ph. D., will speak on "Perspectives in Community Mental Health in Washington, D. C.." Doctor Cohen is Chief, Program Evaluation, Area C Community Mental Health Center, District of Columbia Department of Public Health.

The Conference will get under way on Wednesday, May 7, with meetings of the West Virginia Association of Registered Sanitarians and the Executive Council and the Sanitarians Party.

On Thursday evening, the annual reception, banquet and dance will be held.

Dr. Morris F. Collen, Director, Medical Methods Research, The Permanente Medical Group, Oakland, California, will be the first speaker on Friday morning. His topic will be "Experience with the Automated Multiphasic Screening Program of the Permanente Medical Group."

Jerrold Michael, Assistant Administrator, Bureau of Consumers Protection and Environmental Health Services, will speak on "Trends in Delivery of Environmental Health." Following this talk there will be a panel discussion on the subject of "Innovations and Change in Environmental and Personal Health Care in West Virginia."

Various sections of the Public Health Association will have their own programs on Thursday and Friday afternoons.

American Heart Association Calls for Abstracts

Abstracts of papers and applications for scientific exhibits and cardiovascular films to be considered for presentation at the 1969 Scientific Sessions of the American Heart Association must be postmarked no later than June 6, the AHA has announced.

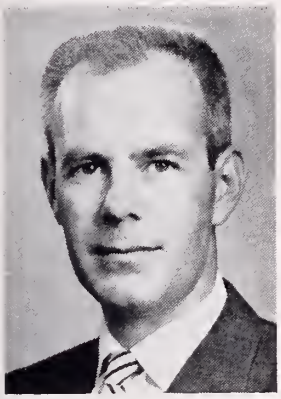
The meeting will be held in Dallas, Texas, November 13 through November 16, 1969.

Papers proposed for presentation must be based on original investigations in the cardiovascular or related fields. The project's results and the investigator's conclusions must be summarized in the abstract and submitted on official AHA forms.

Official forms for submitting abstracts, films and exhibits may be obtained from: Department of Medical Education, American Heart Association, 44 East 23rd Street, New York City, New York 10010.

Speakers and Titles Listed For EENT Meeting

The complete scientific program for the National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology has been announced by Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary - Treasurer of the Academy.



John A. Dyer, M. D.

Approximately 400 physicians and guests are expected to attend the sessions at The Greenbrier in White Sulphur Springs, April 20-23.

The registration desk will be open from 9 A.M. to 5 P.M. on Sunday, April 20. A registration fee of $50, which covers the scientific sessions and social events, will be charged to nonmembers of the Academy.

Ophthalmology Program

Doctor Blaydes said there will be four guest speakers on ophthalmology and four on otolaryngology. Speakers on ophthalmology and their titles are as follows:

Irving H. Leopold, M. D., New York City: "Challenges in Glaucoma Management" and "Therapy of Intraocular Infection."

John A. Dyer, M. D., Rochester, Minnesota: "Techniques of Fitting Small, Thin Corneal Contact Lenses" and "Possible Complications from Wearing Contact Lenses."

Marshall M. Parks, M. D., Washington, D. C.: "Management of Cataracts in Infants and Children" and "Advances in Strabismus Surgery Techniques."

Charles L. Schepens, M. D., Boston, Massachusetts: "The Choice of Procedure in Retina Surgery" and "Recent Advances in the Management of Retina Detachment."

Otolaryngology Program

Speakers on otolaryngology and their subjects are as follows:

Harold F. Schuknecht, M. D., Boston, Massachusetts: "Sensorineural Deafness: Pathology and Management" and "Tympanoplasty: Methods and Results."

Joseph H. Ogura, M. D., St. Louis, Missouri: "Surgical Treatment for Cancer of the Larynx and Pharynx, Including Conservative Surgery" and "Pre-Operative Irradiation for Cancer of the Head and Neck, Including Reconstructive Surgery."

J. R. Chandler, M. D., Miami, Florida: "Diseases and Surgery of the External Auditory Canal" and "Bell's Palsy or Not."

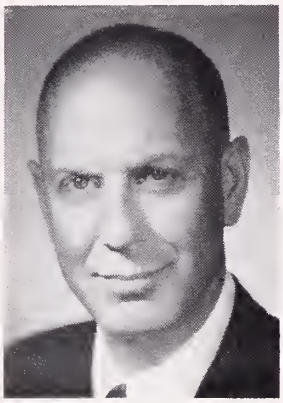
Louis E. Silcox, M. D., Philadelphia: "Allergy of the Nose and Paranasal Sinuses: Present Concepts in Diagnosis and Therapy" and "The Antihistamines: Past, Present and Future."

Doctor Blaydes said a full program of activities for ladies has been arranged.

Officers of the Academy in addition to Doctor Blaydes are: Dr. Edward Shupala of Parkersburg, President; Dr. Charles M. Polan of Huntington, Vice President; and Drs. Nime K. Joseph of Wheeling, Albert C. Esposito of Huntington, and Philip M. Sprinkle of Morgantown, Directors.

Checks for registration fees should be made payable to "West Virginia Academy of Ophthalmology and Otolaryngology" and mailed to Doctor Blaydes at 107 Federal Street, Bluefield.

Irving H. Leopold, M. D.



Harold F. Schuknecht, M. D.

Teaching Hospital Council Elects Dr. Morgan

Approximately 35 physicians, hospital administrators and others met in Charleston on March 13 to take preliminary steps toward organizing the West Virginia Joint Council on Teaching Hospitals.

The Joint Council is a subsidiary organization of the West Virginia State Medical Association and the West Virginia Hospital Association.

The group did not formally organize itself but did elect temporary officers. Dr. David Z. Morgan of Morgantown, Assistant Dean of the West Virginia University Medical School and a member of the State Medical Association's Committee on Medical Education and Hospitals, was elected Chairman Pro Tempore.

Elected Secretary Pro Tempore was Mr. Edward D. Hagan of Charleston, Assistant Executive Secretary of the West Virginia State Medical Association.

All 12 West Virginia hospitals which operate approved internship and/or residency programs were represented by one or more members of their medical and administrative staffs. Also represented were certain other hospitals, the Committee on Medical Education and Hospitals and the Executive Committee of the West Virginia Hospital Association.

Much of the meeting was devoted to discussion of philosophy and objectives and purposes of the Joint Council.

Doctor Morgan said he would appoint a Committee on Constitution and By-Laws in the near future. This group will draft organizational documents for consideration by the Council at its next meeting, probably in May.

Dr. Vernon L. Dyer Celebrates 50th Year in Practice

Dr. Vernon L. Dyer of Petersburg, one of West Virginia's best known rural general practitioners, celebrated his 50th year in practice in Grant County on February 14.

Vernon L. Dyer, M. D.

The occasion did not go unnoticed by Grant Countians. More than 300 persons turned out for a dinner and program honoring Doctor Dyer. Attorney James Paul Geary served as toastmaster, and Dr. Roy S. Harman, a Petersburg dentist, narrated a "This Is Your Life" skit.

Mayor William W. Welker proclaimed the week of February 12 as "Dr. Vernon L. Dyer Week" in Petersburg in recognition of Doctor Dyer's "long and admirable period of dedication and service to his profession and to the people of our city and community."

Among those present for the Anniversary Observance were all of Doctor Dyer's living brothers and sisters; his daughter, Mrs. John Oliver; and the third baby that Doctor Dyer delivered after opening his practice in Petersburg in 1919. His only son, Dr. John L. Dyer, an ophthalmologist at The Mayo Clinic, had planned to attend, but his flight was cancelled because of bad weather.

Born in Fort Seybert, West Virginia, in 1892, Doctor Dyer attended Shepherd College and received his M. D. degree from Loyola University School of Medicine in 1918. He is serving his second term as President of the Potomac Valley Medical Society and is also a member of the West Virginia State Medical Association and the American Medical Association. He was the State Medical Association's "General Practitioner of the Year" in 1963.

Services Catalog Is Offered By Drug House

Smith Kline and French Laboratories of Philadelphia recently released its *SK&F Services Catalog 69/70.*

The 50-page publication lists medical films, booklets, periodicals, speakers bureau and other services available to physicians.

Physicians may obtain a copy free of charge by contacting their SK&F representative or by writing to: Services Department E - 10, Smith Kline and French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

April 9-11—Maryland Medical, Baltimore.
April 10-11—W. Va. Chap., Am. Acad. of Ped., Princeton.
April 13-17—Am. Assn. of Neur. Surg., Cleveland.
April 16-19—W. Va. Chap., ACS, White Sulphur Spgs.
April 18-20—Am. Soc. of Int. Med., Chicago.
April 20-23—W. Va. Acad. of Oph.-Otol., White Sulphur Springs.
April 21-23—Am. Acad. of Ped., Boston.
April 21-25—ACP, Chicago.
April 21-26—Am. Acad, of Neurology, Washington.
April 25-27—W. Va. Chapter, AAGP, Wheeling.
April 28-May 1—Am. Col. of Ob. & Gyn., Bal Harbour, Florida.
April 30-May 1—Am. Ped. Soc., Atlantic City.

May 5-7—Am. Gyn. Soc., New Orleans.
May 5-9—Am. Psychiatric Assn., Miami Beach.
May 6-7—Assn. of Am. Phys., Atlantic City.
May 12-15—Am. Urological Assn., San Francisco.
May 12-16—Ohio Medical, Columbus.
May 24-26—Am. Thoracic Soc., Miami Beach.
May 26-28—Am. Oph. Soc., Hot Springs, Va.

June 2-6—Am. Col. of Allergists, Washington.
June 18-20—Nat. Conf. on Coronary Care Units, Denver.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.

July 18-19—Rocky Mtn. Cancer Conference, Denver.
July 11-12—Rocky Mtn. Cancer Conference, Denver.
July 13-17—AMA, New York.

Aug. 18-20—Am. Hosp. Assn., Chicago.

Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 6-12—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.
March 31-April 4—Am. Col. of Radiology, Dallas.

The West Virginia Medical Journal

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Chronic Obstructive Pulmonary Disease: Diagnosis and Natural History*

N. LeRoy Lapp, M. D.

Chronic obstructive pulmonary disease is a general term for chronic bronchitis, asthma and anatomic emphysema. These conditions are considered together because they all have in common airway obstruction. The processes by which these conditions come about are different and have been discussed in other papers. The purpose of this presentation is to describe methods of diagnosing these conditions and something of their course or natural history.

Definitions of Simple Ventilatory Tests

Since these diseases have as their hallmark airway obstruction, it follows that the tests of diagnostic importance are those which detect abnormalities in this parameter of ventilatory function. I will, therefore, define some of the most commonly employed tests for detecting airway obstruction and indicate their relative sensitivity and usefulness.. All of these tests except Maximum Voluntary Ventilation are illustrated in Figure 1.

Vital capacity (VC).—This test is defined as the largest volume of air that can be measured during a complete expiration after the deepest inspiration without a rapid effort. It is measured with a spirometer of some type as are all of the tests subsequently described. This is a relatively insensitive test and may be normal or even increased in patients with obstructive airway disease.

Forced vital capacity (FVC).—This is the vital capacity performed with an expiration that is as forceful, rapid and complete as possible. This volume is often significantly reduced in obstructive airway disease and should be one of the measurements made to detect this disease.

*Presented before a meeting of the West Virginia Thoracic Society at the Holiday Inn in Charleston on December 10, 1967.

The Author

- **N. LeRoy Lapp, M. D., Instructor in Medicine, West Virginia University School of Medicine, Morgantown.**

Forced expiratory volume (FEV_T).—This is the volume of gas exhaled over a given time interval during the performance of a forced vital capacity. It should always be qualified by a subscript indicating the time interval in seconds such as 0.5 for the first one-half second or 1.0 for the first one second. It must be compared with predicted normal values and if reduced is a valuable clue to the severity of airway obstruction.

Percentage expired in T seconds (FEV_T %).—This is the volume expired in T seconds expressed as a percentage of the forced vital capacity, that is, $\frac{FEV_T}{FVC} \times 100$. This is a useful way of expressing the timed volume relationship and is relatively independent of age. As a general rule, if this ratio is less than 75 per cent, it indicates airway obstruction.

Forced expiratory flow ($FEF_{200-1200}$).—This is the average rate of flow for a specified portion of the forced expiratory volume; in this instance, the average rate of flow between 200 and 1200 ml. It was formerly called the maximum expiratory flow rate and if slowed in comparison with predicted normal values, is an evidence of airway obstruction.

Forced midexpiratory flow ($FEF_{25-75\%}$).—This is the average rate of flow during the middle half of the forced vital capacity. It was formerly referred to as the maximum midexpiratory flow

rate. This is a sensitive early indicator of airway obstruction and is quite useful as a screening test. There are predicted normal values available based on age and sex.

Maximum voluntary ventilation (MVV).—This is the maximum volume of air which a subject can breathe with voluntary maximal effort for a given time. It formerly was called the maximum breathing capacity. It is a useful test of overall ventilatory capacity including muscle strength, airway obstruction and subject motivation. It usually correlates well with the patient's complaint of dyspnea. Properly done, it can be quite a strenuous experience and may be too tiring for extremely incapacitated patients.

Indications for More Than Simple Ventilatory Tests

The previously described ventilatory tests usually are adequate to diagnose and judge the severity of most cases of obstructive airway disease. They are adequate also for mass screening programs and evaluation of lung function in the great majority of patients suspected of having obstructive airway disease preceding elective surgery. There are, however, certain patients who should undergo a more thorough evaluation:

(1) Those hospitalized because of respiratory infection and especially acute respiratory failure.

(2) Those in whom thoracotomy is planned and especially if pulmonary resection may be anticipated.

(3) Those in whom medicolegal considerations require more than simple tests that detect airway obstruction.

(4) Those whose history of dyspnea or whose performance in the ventilatory tests seems unreliable.

Chronic Bronchitis

Clinical Picture.—Characteristically, the patient is a male in early middle age, a cigarette smoker, and one who will somewhat reluctantly admit to a productive morning cough. The amount of sputum usually is greatest in the morning. He may notice a wheezy sensation in his chest at times and that colds tend to settle in the chest or that he may have lost time from work in the recent past due to chest illnesses. He may have had hemoptysis. Initially, there is little dyspnea except during periods of respiratory infection.

Physical examination at rest may be completely normal. Often there is an audible expiratory wheeze during a maximal expiration or after coughing.

Roentgenographic Changes.—Plain roentenograms of the chest may be and indeed usually

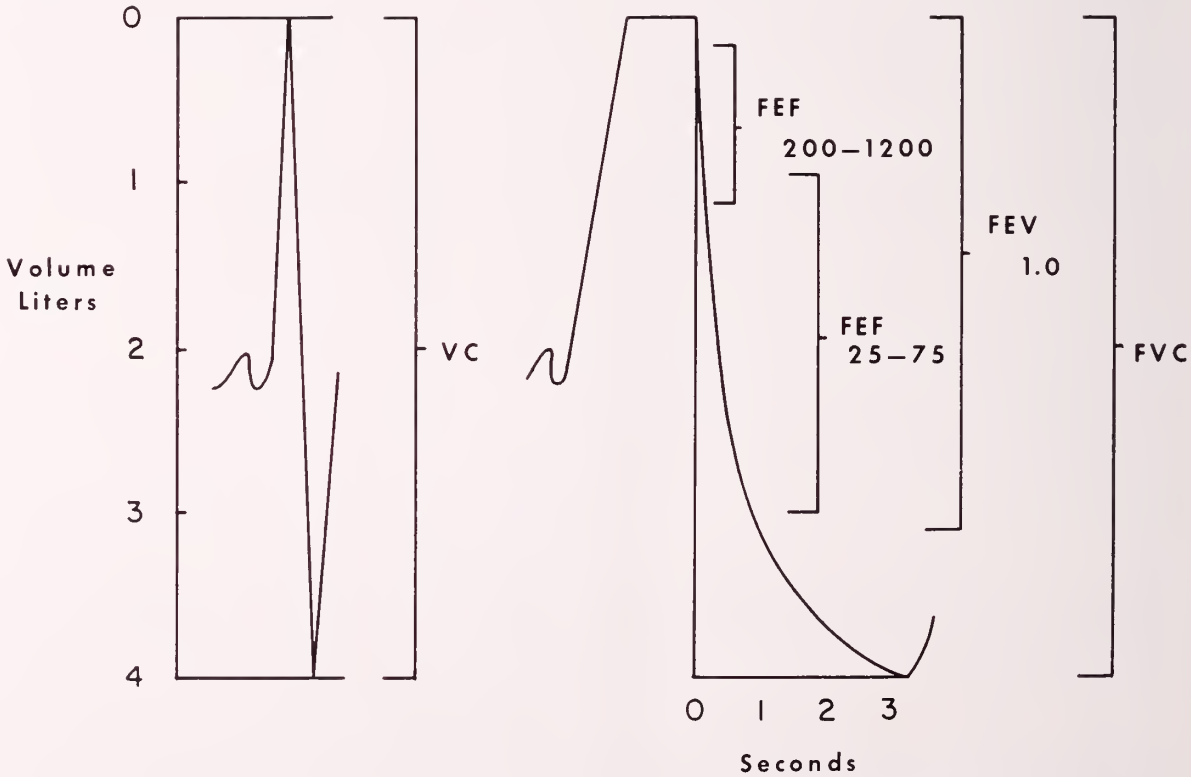

Figure 1. On left is a vital capacity maneuver. Diagram on right is a volume versus time tracing of a forced vital capacity maneuver. See text for definitions of the abbreviations.

are completely normal early in the course of bronchitis. They serve only to exclude other diseases which may be associated with or mimic chronic bronchitis. The pathognomonic sign of this disease can be seen on bronchograms which may demonstrate enlarged bronchial glands that are sometimes wide enough to be filled with the contrast medium.[1]

Natural History.—The normal bronchial mucosa produces about 100 ml. of mucus per twenty-four hours. The mucus forms a protective blanket which is propelled continuously upward by the action of cilia in the brush border of the mucous lining cells. It has been demonstrated experimentally that inhalation of cigarette smoke and other toxic substances causes ciliary stasis and decreased clearance of bacteria and other particles from the bronchial tree.[2] Whether or not mucous gland hypertrophy and oversecretion are attempts to compensate for this decreased clearance is not known. Patients with chronic bronchitis produce volumes of mucus of the order of double or triple the normal volume.

The role of infection in this disease is not entirely clear. Most studies have shown that both *D. pneumoniae* and *H. influenzae* play an important part in the acute exacerbations of respiratory infection manifested by increased or purulent sputum and increasing dyspnea or wheezing.

Chronic bronchitis does not always lead to morphologic emphysema but the two frequently are associated.

Ventilatory Tests of Value.—Since by definition chronic bronchitis implies cough and sputum production not due to other causes, there has arisen some confusion as to the abnormalities in pulmonary function produced by this condition. Most observers agree, however, that there is reduction in the forced expiratory flow, especially over the middle half of the FVC. These tests in general correlate well with the history of dyspnea and the volume of sputum production. There are, however, a few subjects who meet the historical criteria for the diagnosis of chronic bronchitis who demonstrate normal or nearly normal ventilatory function. Other abnormalities that have been reported in this disease are slight overinflation, increased airway resistance and uneven ventilation as measured by inert gas distribution.

Asthma

Since the clinical picture and natural history are well known, this discussion will include only the radiological picture and ventilatory tests of value.

Roentgenographic Changes.—Radiographic examination in symptomatic asthma usually reveals evidence of overinflation of the lungs as manifested by increase in the anteroposterior diameter of the chest, flattening of the diaphram and increase in the retrosternal air space. The caliber of the pulmonary arteries and veins usually is not altered. This latter finding is better seen on full lung tomograms but often is appreciated as well on the plain chest film. Preservation of the pulmonary vessels is the main finding that differentiates asthma from emphysema on a radiographic basis.

Bronchograms may be hazardous if done during a symptomatic period, and done during a symptom free period seldom shows any abnormalities.

The presence of linear densities that follow the bronchial distribution probably is indicative of peribronchial fibrosis or of the coexistence of chronic bronchitis with the asthma. Early in the course of asthma, the chest roentgenogram frequently is normal.

Ventilatory Tests of Value.—Patients with moderately severe clinical bronchospasm invariably have a reduced forced vital capacity and the volume exhaled in one second. Maximum voluntary ventilation and forced expiratory flow over the middle half of the FVC also are reduced. It is common practice to repeat these ventilatory tests after inhalation of a bronchodilator aerosol such as isoproterenol. In many patients with asthma this will produce dramatic changes in the flow rates and increase the FVC. In others, such changes will occur spontaneously. In patients with status asthmaticus such changes may be observed only after an intensive course of therapy over a period of several days to weeks.

Other abnormalities that have been observed in asthma are increased airway resistance, increased residual volume, and uneven ventilation as measured by inert gas distribution. Many investigators have shown that even though spirometric measurements may be normal during the symptom free periods, asthmatics have abnormally elevated airway resistance.

In spite of what has been said about the ventilatory tests in asthma, it must be emphasized that the diagnosis rests largely upon historical grounds. The ventilatory tests are mainly confirmatory and are useful in assessing the degree of impairment and responsiveness to therapeutic measures.

Emphysema

Since this is an anatomical diagnosis and one that seldom can be established firmly during

life, outlining too dogmatically the so-called diagnostic clinical and radiographic features of this disease would be hazardous.

Clinical Symptoms.—The clinical symptoms of emphysema usually have their onset in the forties and fifties. Initially, the shortness of breath is variable, often depending on climatic conditions. It usually occurs with exertion but frequently is so insidious that the individual has little or no awareness that he has gradually reduced his activities. Usually the patient has been a cigarette smoker for many years. Most give a history of cough, especially in the morning, but sputum production frequently is not noted until exertional dyspnea has limited the exercise tolerance.

Physical examination discloses increased anteroposterior diameter of the chest, widened interspaces, depressed diaphragm, and diminished breath sound transmission characteristic of lung hyperinflation. Not all hyperinflation, however, is due to anatomic emphysema and the unreliability of the clinical detection of emphysema is well established.

Roentgenographic Changes.—Diagnosing emphysema by the criterion of lung hyperinflation from a single PA chest film is fraught with error as has been adequately shown by the generally poor correlation with autopsy studies. Accuracy of the radiological diagnosis of emphysema can be improved if PA films are made both in full inspiration and full expiration and an attempt made to estimate the reduction in pulmonary vasculature. The status of the pulmonary vasculature can be better assessed by full lung tomograms. Although pulmonary angiograms produce better visualization of the vasculature, they add little more than can be deduced from the tomograms. Bronchograms probably are less helpful in diagnosing emphysema than in chronic bronchitis because of the frequent difficulty in filling the more peripheral radicals.

Natural History.—In general, emphysema is slowly, but relentlessly, progressive. Factors that tend to accelerate the progression are smoking, recurrent exposure to smog, air pollution and other noxious inhalants, and acute infections. Many patients with severe ventilatory impairment continue for years with a normal arterial pCO_2 and without developing cor pulmonale. Indeed, cor pulmonale is more often associated with chronic bronchitis than with emphysema. Acute infection or bronchiolitis from exposure to smog, however, may result in sudden severe hypoxia and respiratory failure or cor pulmonale.

Ventilatory Tests of Value.—Resting ventilation early in emphysema is not strikingly different from that in normal subjects. In contrast, the maximal voluntary ventilation (MVV) is invariably reduced. The forced vital capacity and volume in one second are considerably below normal values. Forced expiratory flow over the middle half of the FVC usually is impaired. There is characteristically little significant improvement in these parameters after administration of bronchodilator aerosol. In contrast to asthma, however, the impairment in expiratory flow usually is much more severe than the impairment in inspiratory flow. Other function tests reveal hyperinflation and marked degrees of uneven mixing of inert gases. Airway resistance usually is elevated to several times the normal value. The best correlations between anatomic emphysema and clinical tests are found when lung compliance, elastic recoil, and diffusing capacity are measured.

Summary

Tests of ventilatory function that are useful in diagnosing and judging the severity of chronic obstructive pulmonary disease are reviewed. The clinical picture, roentgenographic changes, and natural history of chronic bronchitis, asthma and emphysema are presented briefly. Abnormalities in ventilatory tests produced by these conditions are mentioned. It should be emphasized that the ventilatory tests commonly used measure the degree of airway obstruction and are not necessarily specific for any one of the three major causes of airway obstruction. Precise diagnosis of the underlying cause of obstructive airway disease requires a history, physical examination, roentgenographic examinations, and tests of ventilatory capacity.

References

1. Bates, D. V., and Christie, R. V.: Respiratory Function in Disease, Philadelphia, W. B. Saunders Co., 1965, p. 155.
2. Dahlman, T.: Effect of Cigarette Smoke on Ciliary Activity, Am. Rev. Resp. Dis. 93:109-114 (March) 1966.

118th Annual Convention AMA NEW YORK CITY JULY 13-17, 1969

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Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, July 16, 1969. Since space is limited, we suggest you make your reservations before June 30, 1969. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969.

NEW YORK CITY, NEW YORK • JULY 13-17, 1969
AMERICAN MEDICAL ASSOCIATION'S 118th ANNUAL CONVENTION

Implantable Pacemaker for Correction Of Complete Heart Block

(A Survey in the State of West Virginia)

Walter H. Gerwig, Jr., M. D., William A. Jacobs, M. D., and Catalino B. Mendoza, Jr., M. D.

Use of the implantable pacemaker has been vital in cases of patients with complete heart block. Long-term cardiac stimulation utilizing an implantable pacemaker and myocardial electrodes has been used with increasing frequency since 1960.[1,2,3,4,5] Treatment of complete heart block associated with Stokes-Adams syndrome attacks by artificial pacemakering has become an established and accepted procedure.

Zoll,[5] in 1952, demonstrated that patients with complete heart block could be effectively stimulated by external pacing. This method caused constant pain and discomfort to the patient and frequently resulted in burns of the skin at the sites of electrode contact. To avoid these problems subsequent operative procedures were developed in which the electrodes were inserted directly into the epicardial surface, being powered by an implantable unit which was placed in the abdominal wall. Even though this form of treatment required thoracotomy, it did eliminate the aforementioned objections, and soon began to replace the older and less satisfactory method.

More recently, especially for patients in whose cases thoracotomy may be contraindicated, a method for permanent transvenous intracardiac pacing has been developed.[6] The power unit for this modality is implanted subcutaneously in the region of the right clavicle. This type of management, in our experience, has not been without certain drawbacks that preclude its wholehearted acceptance and endorsement.

In cases in which acute complete A-V block develops as the result of myocardial infarction, myocarditis, or other cause, temporary transvenous pacing with a catheter electrode of the Parsonette type can be connected to an external unit so that the rate and intensity can be adjusted and may provide adequate myocardial function until the disease process improves and a sinus mechanism has returned. For those cases in which there is chronic, persistent heart block with repeated Stokes-Adams attacks, implantation of a permanent unit placed subcutaneously in the abdominal wall and connected to epicardial electrodes is more desirable.

Submitted to the Publication Committee, October 30, 1968.

The Authors

- **Walter H. Gerwig, Jr., M. D., Professor of Surgery, Wayne State University School of Medicine; and Chief of Surgery, Allen Park Veterans Hospital, Detroit, Michigan.**
- **William A. Jacobs, M. D., Staff Physician, VA Hospital, Clarksburg; and Clinical Instructor in Medicine, West Virginia University School of Medicine, Morgantown.**
- **Catalino B. Mendoza, Jr., M. D., Staff Surgeon, VA Hospital, Clarksburg; and Instructor in Surgery, West Virginia University School of Medicine, Morgantown.**

Method

Letters were sent to 94 hospitals and clinics listed as being licensed by the Department of Health in the State of West Virginia inquiring as to the status of patients who had been admitted with a diagnosis of complete heart block and as to therapy with electrical cardiac stimulation. Complete responses were received from 35; the results are tabulated in Table 1.

Discussion

Our two-year survey reveals that there are seven hospitals in West Virginia in which the implantation of internal pacemakers is being carried out. These institutions are widely distributed throughout the state and are well equipped to provide this type of patient care.

It is noted that the West Virginia Medical Center performed the largest number (36) of pacemaker implantations during the period under study. This institution was among the three admitting the largest number of patients (10,289) which may be accounted for in that it is a re-

Table 1
Hospitals and Clinics in the State of West Virginia Implanting Internal Pacemakers
1964-1966

Name of Hospital	*No. Yearly Admissions*	*No. Internal Pacemakers*	*Ratio of Implantations per 1000 Admissions*
Beckley Appalachian Regional, Beckley	7,998	5	0.62
Chesapeake & Ohio, Huntington	4,563	9	1.90
Memorial Hospital, Charleston	12,707	10	0.80
Ohio Valley General, Wheeling	12,700	5	0.40
Pleasant Valley Hospital, Point Pleasant	1,500	1	0.66
Veterans Administration Hospital, Clarksburg	2,314	13	6.50
West Virginia University Medical Center, Morgantown	10,289	36	3.50

ferral hospital and receives patients from all over West Virginia as well as from nearby states. The Clarksburg Veterans Hospital had 2,314 admissions, of which 13 were treated by pacemaker implantation. In all 13 cases, implantation of a pacemaker has thus far prevented any recurrence of the Adams-Stokes syndrome. This is comparable to the observations of other investigators.[1,2,3,4,5]

Zoll,[3] et al, in their series of 77 cases, found that the longest period an individual has had internal implantable pacemaking is about 40 months.

Summary

A survey of the use of long-term cardiac stimulation with implantable pacemakers and myocardial electrodes by various West Virginia hospitals licensed by the State Department of Health, is presented.

It is possible that patients in other institutions can be prepared with the external pacemaker and transferred to the nearest center for the permanent internal pacemaker implantation.

Our study shows that implanted pacemakers have prevented recurrence of the Adams-Stokes syndrome in 13 cases, which is comparable to the observation of other investigators.[1,2,3,4]

Acknowledgment

To the Medical Records Department of each of the hospitals furnishing data used in this paper and to the State Department of Health for the list of licensed hospitals and clinics in West Virginia, acknowledgment and appreciation are expressed.

Reprint requests should be directed to Dr. Catalino B. Mendoza, Jr., VA Hospital, Clarksburg, West Virginia 26301.

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Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

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Podiatry: A Boon, Not a Boondoggle*

H. Lamont Pugh, M. D.

"That man is by no means poor who has the use of everything he wants. If it is well with your belly, your back and your feet, regal wealth can add nothing greater."

Horace
Epistles—Book I, Chapter XII
To Iccius—Line 4

The Author

- **H. Lamont Pugh, M. D., former Surgeon General of the Medical Corps of the United States Navy, 3579 South Stafford Street, Arlington, Virginia 22206.**

WHETHER the above excerpt from one of Horace's letters may be regarded as an over or an under statement is really not important. The fact that he did include good feet as essential to a state of well-being is significant. This desideratum is no less genuine in our modern day of mechanization and multifarious modes of locomotion—from golf carriages to rocket propelled space ships—than it was in the time of Horace (65-8 B. C.) when people either walked or rode plodding beasts, or they didn't go.

To the end of promoting or preserving feet free from defects, and of relieving disorders to which the feet of people are prone, or, in collaboration with orthopedic surgeons, of salvaging maimed or crippled feet, the profession of podiatry has come to occupy a place in the front rank of those dedicated to the healing arts and sciences—and it has attained its status with integrity and dignity.

Inasmuch as the academic and professional training requirements for the discipline of podiatry have not long ago been clearly defined in a letter written by R. M. Cox, M. D., Secretary-Treasurer of the Virginia Board of Medical Examiners, to the physicians in the State of Virginia, and in which letter Doctor Cox made definite reference to the importance of specialists in this field as an ancillary resource to the practitioners of medicine and surgery—particularly of orthopedic surgery—a repetition of these aspects of podiatry would be pointless. This view is further supported by the fact that as recently as April, 1967, there appeared in *The West Virginia Medical Journal* a "Special Article" entitled: The Podiatrist—An Important Aid to the Medical Profession, by H. Darrel Darby, D.S.C. (Doctor of Surgical Chiropody—This title has quite recently been changed to Doctor of Podiatric Medicine). In that article Doctor Darby stressed the high level organizational features and the thorough training requirements for the profession of podiatry. The training requirements are indeed comparable with those for the practice of medicine.

This writer has never known of a single instance of dissatisfaction on the part of an individual whose feet had been or were being treated by a podiatrist. On the contrary, they have been unanimous in their acclaim of the brand of treatment received and the gratifying results obtained, which in many instances was more than could be said for the care of their feet rendered to them by their family physician or orthopedic specialist. The demands upon the time and resources of good orthopedic surgeons and general practitioners alike are too great to permit them to devote the painstaking care to many common but frequently genuinely crippling disorders of people's feet. Therefore the podiatrist is a highly valuable—and hopefully a highly valued—ally of the medical profession. If there be those among the disciples of medicine or among the public at large who are benighted by the idea that since podiatry deals with the pedal extremity, podiatrists constitute the low figures on the "totem pole," they are definitely and unfortunately mistaken.

Five Colleges of Podiatry

There are five colleges of podiatry in the United States—one in Chicago; Cleveland, Ohio; San Francisco; Philadelphia and one in New York City. As pointed out by Doctor Darby, these colleges are independent, incorporated non-profit institutions, governed by charters, supervised by boards of trustees, regulated by state departments of education, and listed in the Directory of Institutions of Higher Education of the U. S. Department of Health, Education and Welfare. Podiatrists are licensed in every state, the District of Columbia and in the Commonwealth of

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Puerto Rico. Like medicine, podiatry has its National Board. It is recognized in 34 states.

The College of Podiatry in New York City is the oldest and most noted in the United States. This distinction stems from the founder of that College, Maurice J. Lewi, M. D., graduate of Albany Medical College in the class of 1877. Since the death of Doctor Lewi—within a few months of his one hundredth birthday, and in tribute to this amazing man—the name of the New York College of Podiatry has been changed to the M. J. Lewi College of Podiatry.

It was incident to negotiations between Doctor Lewi and this commentator, when the latter was the Surgeon General of the Navy, and the former was the long time President of the New York College of Podiatry (a sprightly, agile, energetic, enthusiastic and exceedingly personable man in the 96th year of his life who, among other factors, attributed his longevity to his never having wasted any energy resisting temptation) that podiatrists were admitted to the Navy's Medical Corps (one of the five corps that comprise the Medical Department of the Navy).

In compliance with my recommendation a Podiatry Section in the Medical Service Corps of the Navy was established by the Secretary of the Navy on 3/November/1953. Thus the Medical Department of the Navy became the first of the Medical Departments of any of the branches of the U. S. Armed Forces to utilize the talents and capabilities of the podiatry profession. Presently there are billets in the Navy for 10 podiatry officers. An eleventh billet is in process of being created.

In 1957, five podiatry officers were commissioned in the Army. At present there are 55 billets for commissioned podiatrists in the Medical Service Corps of the U. S. Army.

The U. S. Air Force Specialty Code for podiatrists was established as recently as 1967. Three podiatrists have been commissioned and provision for the commissioning of three additional specialists in this category of that Armed Services branch has been made for the next fiscal year.

Usefulness of Podiatrists in the Armed Forces

During the latest six months period for which statistics have been compiled in the Navy's Bureau of Medicine and Surgery in Washington, D. C., 4,085 treatments were administered at the podiatric clinic of the U. S. Naval Training Center, San Diego, California. During the same period at the U. S. Marine Corps Recruit Depot, San Diego, California, a total of 3,708 treatments were rendered at the podiatry facility of that station. Thus may a fair example be had of the usefulness of podiatrists in the Nation's Armed Forces. The conditions cared for in the foregoing numbers of treatments ranged all the way from blisters to stress, fatigue or march fractures. As might be expected, in Naval and Marine Corps training centers or depots, pes planus, foot stain, ingrowing nails, bursitis and plantar warts constitute the more common conditions with which podiatrists have to deal. However, the above mentioned semi-annual reports from the San Diego Naval and Marine Corps training stations list 22 and 24 specific foot ailments in their respective totals of 4,085 and 3,708 treatments credited to the podiatrists on duty at these establishments.

That Armed Services personnel by and large are no better than their feet is a reasonably accurate observation, and devotees to the specialty of podiatry are contributing liberally to the positive side of this equation.

As it is with the practice of medicine, podiatry is "a calling, not a business—an art, not a trade." Similarly as is true of all of the bona fide healing arts, podiatry is a profession. As defined by the late Louis Dembitz Brandeis, Associate Justice of the Supreme Court of the United States (1916-1939) "A profession is an occupation for which the necessary preliminary training is intellectual in character involving knowledge and to some extent learning as distinguished from mere skill. It is an occupation which is pursued largely for others and not merely for one's self. It is an occupation in which the amount of financial return is not the accepted measure of success." Podiatry meets the criteria so specified by Justice Brandeis.

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Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
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Special Article

Health Profiles of Three Hollows in West Virginia

Ernest W. Chick, M. D., Marilyn A. Jarvis-Eckert, M. D., and Roger E. Flora, Ph. D.

In 1964, the West Virginia University Center for Appalachian Studies and Development initiated a study involving three semi-isolated, rural, disadvantaged communities. The initial phase of the study was to define the demographic characteristics of these communities and to establish working relations with the people. Subsequent phases have been to help the people in these communities to learn to work together in community endeavors rather than to follow their previous pattern of individualism and to establish improved living, social and working conditions.

During the initial phase of the program, the Division of Preventive Medicine and Public Health of the School of Medicine was invited to participate in the study. It was decided that initially there should be an appraisal of the health status of the community, and then programs involving community health could be instituted, based on these findings.

This report summarizes the results of the medicodental surveys in the three study communities.

Method of Survey

The medicodental survey may be divided into three phases. First, representatives of the Appalachian Center prepared the communities by stimulating interest in participation by the people. One or two medical students then spent from 5 to 10 days in each community, completing a detailed questionnaire by interviewing a responsible member (usually the mother) of each household. The questionnaire provided information concerning family origin, length of time in the community, sanitation, and income level of the household. A past history of illnesses and of immunizations was obtained for each individual in the household. Utilization of medical services and methods of payment were detailed.

In the absence of health facilities, arrangements were made for the examinations in three-room churches in two of the communities and in a four-room house that was used as a community center (and home for two VISTA volunteers) in the third community. Ordinary tables, chairs and the like for use in examinations were supplied by the people. Water was hauled in by conservation officers or local volunteers. Toilet facilities were dug pit privies in each instance. Heavy duty electric outlet boxes were tem-

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The Authors

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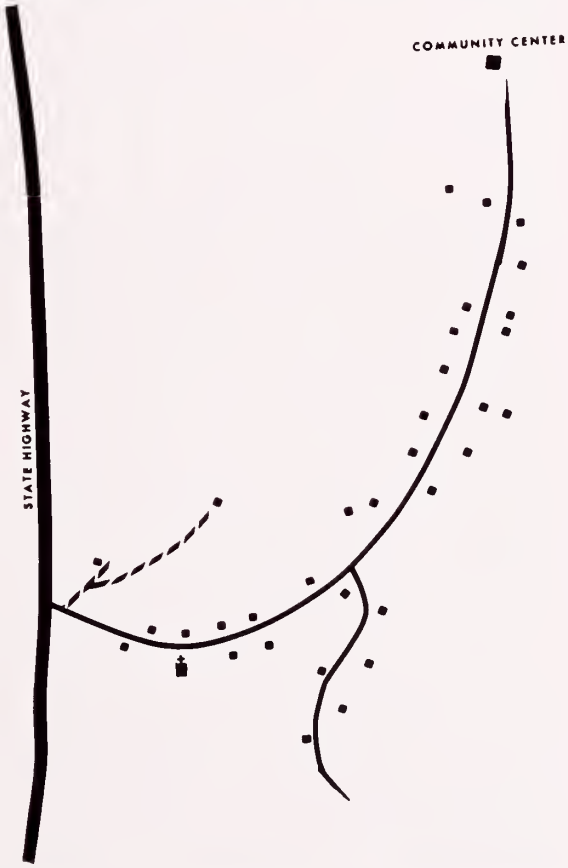

Figure 1. Map of Community 2. The other communities are similar.

porarily installed by the local power companies. All medical, dental and laboratory instruments were transported from the Medical Center.

After review of the questionnaire data, a medicodental team spent from three to five days in each community carrying out the examinations. The team consisted of two physicians, one dentist, and one nurse from the faculty of the University Medical Center, two or three medical students, one or two dental students, one dental hygiene student, two or three nursing students, two or three medical technology students, and one microbiology graduate student. Examinations included height, weight, vision testing, dental examination, physical examination and laboratory studies including hematocrit, white cell count and differential, urinalysis and stool examination for parasites. Electrocardiograms were taken on all individuals over 40, or younger, if indicated, and Papanicolaou smear of the cervix of females over 20. Tuberculin and histoplasmin skin tests were done on all individuals examined.

On return to the Medical Center, electrocardiograms and Papanicolaou stains were read. The data were then processed and analyzed on an IBM 7040 computer. A member of the team returned to each of the communities and apprised a responsible member of each household of the examination results of each individual in the household. A listing of the abnormal findings of the examinations was mailed to the physician designated by the examinee.

The Communities

The three communities involving 136 households and 516 persons are located in the central portion of West Virginia. All are within a 35-mile radius of an urban center. Each community is located off a paved state highway along a meandering dirt road (Figure 1). All may be classified as semi-isolated, rural, non-farm, nonmine communities.

The population of each community is detailed in Table 1 by number of households, number of persons, and average number of persons per household. Communities No. 2 and No. 3 are similar. Community 1 is approximately twice the size of either of the others, and has somewhat fewer persons per household. Ninety per cent of grandparents are from West Virginia. There were no foreign-born grandparents. The communities are relatively stable as indicated by the number of years each household has lived continuously in that community (Table 2). The age and sex distribution of the communities are given in Table 3.

The average annual income of households classifies these communities as disadvantaged, since over 50 per cent have incomes of less than $3,000 (Table 4). Ten per cent have incomes of $7,000 or greater and represent individuals who commute to the urban center and have established jobs in various industries. The majority of the working population are found in low paying or part-time occupations, such as road construction or mechanic. The education level of adults in the communities is low, with the majority having less than a ninth grade education (Table 5).

Sanitary facilities leave much to be desired. Seven of the 136 households have no toilet facilities (Table 6). Thirteen households have a privy and 79 a dug pit privy, many of which appeared of improper construction. Only 36 had septic tanks. Drinking water is not easily accessible to much of the population (Table 7). Eleven households relied on a spring or cistern as a source of water; however, proper construction and protective measures were not uniformly observed. Twenty-six households relied on a dug well, again with question of proper protection of the well. Seventy-eight households had drilled wells.

Patterns of Health Care Utilization

The facilities and personnel used for delivery appears to offer an objective method of appraisal of health care utilization of a community over a period of years. Table 8 provides a comparison of usage in the decades 1946 to 1955 and 1956 to 1965. The shift from home delivery to hospital delivery is striking. It is interesting to note that community 1 with a total of 23 deliveries had 19 of the 31 home deliveries in the earlier decade, and seven of the eight deliveries attended by a midwife.

An appraisal of immunization histories provides insight into a community's utilization of

Figure 2. Representative example of homes in the three hollows. Privy is situated on hillside above and behind house. A rough bridge spans the small creek in front.

preventive services. Table 9 compares the number of persons who have had smallpox and DPT immunizations within the five years preceding interview and those who have never had these immunizations. The difference between these groups and the total persons in that age group represents individuals who have had these immunizations more than five years before interview. In West Virginia, it is required that children have smallpox and diphtheria immunizations (DPT recommended) by the first grade. In these three communities immunizations often are delayed until school entrance. Booster immunizations are received during school ages, but few persons in the older age groups tend to maintain them. Table 10 indicates the utilization of newer vaccines for poliomyelitis and measles. Approximately 50 per cent of preschool or school age children and a minority of older age groups have received either Salk or Sabin type vaccines. The communities did participate in county-wide "Sabin Sundays". Vaccination for measles has been poorly utilized, but this should be compared with the history of measles as indicated in Table 12.

With consideration to factors influencing recall, information was obtained as to how many persons had received the services of a physician and dentist during the year preceding interview. Approximately 50 per cent had seen a physician but only 20 per cent had seen a dentist. Eleven per cent had been hospitalized overnight. Six per cent had utilized clinics of the county health department. Less than four per cent had been visited by a public health nurse. Approximately one per cent indicated utilization of vocational rehabilitation services. Table 11 summarizes this data.

Patterns of Disease

A detailed past history of illness was obtained for each person. With few exceptions the patterns, by history, were comparable in the three communities. The usual childhood infectious diseases had been experienced by the majority in the communities (Table 12). The lifetime prevalence of mumps in community 2 has been significantly lower than in the other two areas. Influenza and pneumonia have been frequent infections. Parasitic infestation is a common occurrence. Typhoid fever and hepatitis have been experienced in each community.

Acute and chronic respiratory conditions are common (Table 13). A wide variety of chronic diseases and conditions is reported in the three communities (Table 14). Hemorrhoids and chronic nervous trouble are the most common complaints. Arthritis, rheumatism and high blood pressure follow closely. In the three communities high blood pressure was listed by six per cent of the population, heart disease three per cent, stroke, cancer, or diabetes, each less than one per cent.

Results of Physical Examinations

Three hundred seven of the 516 persons in the three communities volunteered to be examined (Table 15). Fifty-seven per cent examined were females. All age groups were represented. Teen-age and young adult males were reluctant to volunteer for examinations, even though the latter were conducted at night so as not to interfere with work.

Table 16 lists seleeted abnormal findings of physical examination and laboratory studies. Dental conditions were the most common abnormalities found, with most persons needing some type of dental care. In one community the DMF rate (decayed, missing, filled teeth) was 20.0 per person with generally poor personal oral hygiene.

Community Differences

Certain interesting differences between communities were observed. Taking into account the numbers examined in each community, by clinical impression communities 1 and 3 had five times the heart disease found in the other community. In community 3 there were seven persons with thyroid abnormalities, all solitary nodules. In community 1 there were nine persons with varying degrees of diffuse enlargement of the thyroid, none with nodules. No thyroid abnormalities were found in community 2. Eight times as many adolescents (13 to 18 years) in community 1 were found to have acne as in community 2 or 3. Community 3, which had the greatest number of persons with eosinophilia, including many with counts greater than 20 per cent, also had persons with parasites (roundworm, whipworm and hookworm) found on stool examination. A direct relation between eosinophilia and parasitism eannot be established since the stools submitted were relatively few in the other communities. The possibility of allergic reaction accounting for the eosinophilia seems unlikely because of the low prevalence of allergy by history.

Two of the cervical Papanicolaou stains were read as Class IV, or a surprising three per cent positive. It also is interesting that only 25 of the 68 women having Papanicolaou stains ever had had a previous stain. Other lesions suspected of being malignant were found in eight persons and involved the skin, tongue and buccal mucosa.

Follow-Up

A responsible member of each household was informed of the examination results by a member of the examining team who personally visited each home after the findings were tabulated. A list of all positive findings for each individual examined was sent to the physician whom the individual had recorded as the one he would see if indicated. Most of the persons advised to see their physician did so. A special effort was made to have the suspected cancer patients seen by their physicians, and all but one have had, or are under, treatment.

Of the 22 persons with positive histoplasmin skin tests, 17 had a chest x-ray at their county health department. The only active lesion was a coin lesion in one case. Forty-one of the 46 persons with positive tuberculin skin tests also were x-rayed; no active lesions were demonstrated.

Discussion

Rather wide fluctuation was found in the numbers of persons who said they had a disease or condition and those who were found to have it by examination. Many who thought they had a condition did not have it; many were found to have a disease or condition which was not suspected.

These observations raise questions as to the reliability of medical survey information based on questionnaires alone. Verification by comprehensive medicodental examinations is necessary. This cannot be emphasized too strongly in areas in which people usually do not have regular complete physical examinations.

The effectiveness of the survey procedures was enhanced by the efforts of local Cooperative Extension Service Agents and personnel of county health and welfare departments. Without the enthusiastic support of such people who are known in the community and who inspired cooperation in the survey and in follow-up procedures, participation in these studies would have been much less.

It is gratifying to note that the communities actively sought health education programs after completion of the survey to improve their knowledge of health practices and home care. Special programs were designed by Red Cross personnel in collaboration with faculty of the University Medical Center for use in discussion groups in the three communities. These programs were related to areas of need indicated by the participants and to the potential of their environment. Approximately 12 discussion groups have been held in each community with 50 per cent of households being represented.

Prior to initiation of the survey, it was suspected that a wide variety and large numbers of diseases would be found in these semi-isolated disadvantaged hollows. It was surprising to discover that the disease patterns in these three communities were not striking and not unusual from those expected in everyday practice. It was interesting to find that variations in disease patterns existed among the three, however, particularly in relation to certain diseases and the environment. These communities may or may not be representative of other West Virginia communities.

It is difficult to compare the results of this study with previous studies within West Virginia or within the Appalachian Region. Previous studies in West Virginia have largely centered on diseases relating to specific age groups or occupations rather than on a community-wide basis. The National Health Survey data are applicable to the region as a whole, but may not be considered specific for a subsample within the region. Nor is comparison with studies such as the Framingham and Tecumseh surveys feasible since populations, geographic areas, cultural outlook, and methods of study differ.

Summary

Three semi-isolated, rural, non-farm, non-mine communities in West Virginia involving 136 households and 516 persons were surveyed. The three communities had similar socioeconomic, educational and environmental characteristics. Diseases or conditions found by examination differed from those elicited by questionnaire. Interesting variations in certain diseases were found between communities.

Table 1.
Population
Three Kanawha Area Communities
West Virginia, 1965-1966

Community	*Number of Households*	*Number of Persons*	*Average Number of Persons/Household*
#1	67	234	3.5
#2	33	130	3.9
#3	36	152	4.2
Total	136	516	3.8

Table 2.
Number of Years Each Household Has Lived Continuously in Three Kanawha Area Communities West Virginia, 1965-1966

Number of Years	*Communities* #1	#2	#3
0 - 2	1	2	6
3 - 5	2	9	5
6 - 10	9	5	8
11 - 15	8	8	2
16 - 20	3	3	1
> 20	44	6	14
Total Households	67	33	36

Table 3.
Age and Sex Distribution Three Kanawha Area Communities West Virginia, 1965-1966

Per Cent of Each Sex by Age Group in Each Community

Age	#1 *Male*	#1 *Female*	#2 *Male*	#2 *Female*	#3 *Male*	#3 *Female*
0 - 6 Years	18%	11%	8%	23%	16%	21%
7 - 12	15	12	18	17	16	10
13 - 18	15	14	20	11	19	16
19 - 30	11	16	8	15	16	14
31 - 45	18	18	22	15	12	18
46 - 65	15	19	20	11	16	15
> 65	8	9	4	8	5	6
Total Persons	118	116°	65	65	79	73

° One age unknown

Table 4.
Annual Income Levels by Households Three Kanawha Area Communities West Virginia, 1965-1966

Community	< $3,000	$3,000-6,999	$7,000+	Unknown
1	33(49%)	26(39%)	8(12%)	0
2	12(36%)	15(46%)	5(15%)	1(3%)
3	26(72%)	8(22%)	1(3%)	1(3%)
Totals in Per Cent	52%	36%	10%	2%

Table 5.
Highest Education Level of the One Most Educated Adult in Each Household of Three Kanawha Area Communities West Virginia, 1965-1966

Community	*Don't Know*	*School Grade Completed* 0-3 Yr.	4-6 Yr.	7-9 Yr.	10-12 Yr.	> 12 Yr.
1	0	4(6%)	20(30%)	24(36%)	12(18%)	7(10%)
2	0	3(9%)	5(15%)	10(31%)	13(39%)	2(6%)
3	4(11%)	2(6%)	6(16%)	14(39%)	8(22%)	2(6%)

Table 6.
Toilet Facilities for Each Household Three Kanawha Area Communities West Virginia, 1965-1966

Community	*Households*	*Septic Tank*	*Dug Pit Privy*	*Privy*	*No Toilet*
1	67	23	36	5	3
2	33°	7	22	0	3
3	36	6	21	8	1

° One Facility Unknown

Table 7.

Sources of Drinking Water for Each Household
Three Kanawha Area Communities
West Virginia, 1965-1966

Community	*Total Number Households*	*Drilled Well*	*Dug Well*	*Spring*	*Cistern*	*Neighbor*
1	67	29	23	1	0	14
2	33	19	3	3	1	7
3	36	30	0	6	0	0

Table 8.

Obstetrical Care
Three Kanawha Area Communities
West Virginia, 1946-1965

		1946-55	*1956-65*
Live Babies Delivered at:	Hospital	34	66
	Doctor's Office	22	13
	Home	31	1
	Total	87	80
Live Babies Delivered by:	Physician	78	78
	Nurse	0	1
	Midwife	8	1
	Other	1	0
	Total	87	80

Table 9.

Smallpox and DPT Immunizations
Received by Specified Age Groups Within Five Years
Three Kanawha Area Communities
West Virginia, 1961-1966

		Smallpox		*DPT*	
Age in Years	*Total Persons in All Communities*	*<Five Years*	*Never*	*<Five Years*	*Never*
0 - 6	82	41	30	46	21
7 - 18	157	122	4	121	2
19 - 30	68	3	1	2	6
31+	209	2	54	6*	75

* Additional 10 had tetanus only.

Table 10.

Poliomyelitis and Measles Vaccine Accepted by Individuals Within Five Years
Three Kanawha Area Communities
West Virginia, 1961-1966

		Within Five Years		
Age in Years	*Total Persons*	*Salk*	*Sabin*	*Measles*
0 - 6	82	23	42	7
7 - 18	157	70	99	14
19 - 30	68	4	18	1
31+	209	18	64	3

Table 11.

Utilization of Health Care Facilities for 136 Families in Year Preceding Interview
Three Kanawha Area Communities
West Virginia, 1965-1966

Number of Persons	*Had Medical Care*	*Had Dental Care*	*In Hospital Overnight*	*Used County Health Dept.*	*P.H.N. Visited Home*	*Used Vocat. Rehab. Services*
516	274	90	57	35	13	8

Table 12.
Per Cent of Persons in Each Community Giving History of Infectious Diseases in Lifetime of All Age Groups
Three Kanawha Area Communities

Diseases	*Community* I	II	III
Measles	92	93	84
Chickenpox	80	82	---
Influenza	70	74	73
Mumps	74	27	67
Whooping Cough	59	54	54
Pneumonia	15	18	16
Parasites	12	22	24
Scarlet Fever	6	5	7
Typhoid Fever	3	5	3
Hepatitis	3	2	7
Rheumatic Fever	3	2	0
Diphtheria	1	2	2
Tuberculosis	1	1	0
Gonorrhea	1	2	0
Syphilis	0	0	0

Table 13.
Per Cent of Persons in Each Community Giving History of Respiratory Diseases in Lifetime of All Age Groups
Three Kanawha Area Communities
West Virginia, 1965-1966

Disease	*Community* I	II	III
Influenza	70	74	73
Bronchitis	16	22	20
Pneumonia	15	18	16
Repeated Sinusitis	13	25	18
Asthma	4	12	7
Hay Fever	3	1	5
Tuberculosis	1	1	0

Table 14.
Per Cent of Persons in Each Community Giving History of Chronic Diseases and Conditions in Lifetime of All Age Groups
Three Kanawha Area Communities

Disease	I	II	III
Hemorrhoids	12	51	13
Chronic nervous trouble	18	11	14
Arthritis or rheumatism	19	11	11
High blood pressure	12	10	9
Trouble seeing	7	9	22
Varicose veins	7	12	6
Anemia	7	8	7
Heart trouble	7	3	7
Stomach trouble (ulcer)	8	6	3
Trouble hearing	6	4	7
Gallbladder trouble	9	3	3
Tumor, cyst, or growth	6	2	5
Kidney trouble	6	2	2
Chronic skin trouble	4	3	2
Epilepsy, fits, or convulsions	4	2	3
Hernia or rupture	4	2	2
Thyroid trouble	2	2	3
Diabetes	3	1	1
Hardening of arteries	2	1	1
Cancer	0	0	3
Stroke	0	1	1
Mental illness	1	0	1

Table 15.

Participants in Physical Examination by Age and Sex
Three Kanawha Area Communities
West Virginia, 1965-1966

	I		*II*		*III*	
Age	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
0 - 6 Yrs.	17	13	3	7	7	14
7 - 12	15	14	11	8	12	5
13 - 18	9	9	7	5	3	9
19 - 30	3	12	2	4	2	6
31 - 45	8	17	2	5	5	9
46 - 65	7	12	5	5	7	10
65+	5	3	0	4	3	3
Total	64	80	30	38	39	56

Table 16.

Selected Abnormal Findings on Physical and Laboratory Examinations, All Ages
Three Kanawha Area Communities
West Virginia, 1965-1966

Finding	*Number of People or Specimens Examined*	*Number of People or Specimens With Finding*
Visual acuity <20/30	264	61
Blood pressure >140/90	200	47
Heart murmur	307	37
Thyroid enlargement	307	17
Possible malignancy-head region	307	8
Ear infection	276	7
Breast mass	307	3
Hernia	293	2
Abnormality on electrocardiogram	89	37
Papanicolaou stain of cervix	68	
Class II		2
Class III		1
Class IV		2
Tuberculin skin test	292	46
Histoplasmin skin test	198	23
WBC count, >12,000	298	55
Hemoglobin	298	
<10 Gm.		4
>16 Gm.		5
Eosinophiles, > 5%	274	78
Glycosuria	161	2
Albuminuria	161	6
Pyuria	161	1
Parasites in stool	73	14

Your Heart Association can help you help your patients

Your patients and their families might have questions about the heart and blood vessel diseases. Your Heart Association has prepared a variety of pamphlets to assist you in answering their questions in simple non-technical language.

Produced under the guidance of leading cardiovascular specialists, these pamphlets deal with such subjects as heart attack, stroke, hypertension, rheumatic fever, congestive failure, inborn heart defects, varicose veins and other disorders. There are also pamphlets advising on risk factors related to heart attack, including persuasive arguments against cigarette smoking, and a fat-controlled, low-cholesterol diet plan for the general public. Booklets on therapeutic sodium-restricted or cholesterol-lowering diets are also available on a physician's prescription only.

Ask your local Heart Association for a catalogue listing all these free materials and order a supply.

WEST VIRGINIA HEART ASSOCIATION
211 Thirty-Fifth Street, S. E.
CHARLESTON, W. VA. 25304

Courtesy of the Publisher.

A message from . . .

The President

HEALTH CARE: QUALITY, MANPOWER AND COST

I recently returned from the Socio-Economics Congress sponsored by the American Medical Association in Chicago. This was one of the most interesting meetings I have attended in many years. I wish I could write of all of the things that were brought up; however, due to space limitations, I will give some highlights.

The Health Team, which the public is concerned about today, has three important facets: quality; manpower; and probably most important to the public, cost. The inflation which we are undergoing has brought new demands. Of course, today there are expensive techniques performed by highly trained people and this does not come cheaply.

Speaking of quality medical care, we have been accused in some areas of not having medical care of the highest caliber. There are many areas of postgraduate medical education going on and it is important to each physician to avail himself of it. Fortunately, we are able to bring postgraduate medical education into the local area where the physician does not have to travel a great distance. Recently, it has been suggested that a physician be able to assess what weaknesses he may have. In some areas a series of examinations has been prepared for the physicians' edification. This would certainly be interesting and he would have the results shown to no one but himself. There is no question that this would help quality medical care.

Medical manpower is, of course, the cry of the shortage of physicians. The Dean of the George Washington Medical School brought out that it is one school that is going into the double entry type of medical program. This means that there will be two classes taken into medical school each year. Teaching would go on year round and the student would be able to finish in three years. This seems to have some merit as the cry to increase classes reaches a point where it is not workable.

In closing I would like to mention the increase in paramedical personnel. There are about eight colleges or universities teaching different fields of paramedical education. Today approximately 30 more institutions are considering going into this field. I might add that it is no longer called paramedical personnel but allied health professions. Caution is in order, however, as there seems to be a tendency of too many new fields to be opened. In one area they are considering what is called a "stroke technician." Controls will be needed or there will be too many fields. In some schools there is a College of Allied Health being formed independently of the medical school.

With all the recent technical advances being made in medicine and with more to come, it behooves us all to keep up with the changes. It is felt by many there will be sweeping changes in techniques in the 1970s and 1980s.

Richard W. Corbitt MD,

RICHARD W. CORBITT, M. D., *President*

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EDITORIALS

HEALTH PROFILES OF CERTAIN HOLLOWS IN WEST VIRGINIA

Elsewhere in this issue of *The Journal* may be found an article by Chick et al which concerns a survey of the health profile of three semi-isolated rural, non-farm and non-mine communities. These three communities had similar socio-economic, educational and environmental characteristics; the comprehensive study involved 136 households and 516 persons.

It is of interest that the incidence of the common acute infectious diseases, such as chicken pox, influenza, and whooping cough was about the same in these semi-isolated communities. This was also true for pneumonia as well as a number of other conditions. It is noteworthy that there were but few cases of gonorrhea detected, and still more important that there were no cases of syphilis.

It should be emphasized that although these three communities had quite similar demographic factors, the patterns of disease showed differences both in type and in number. The type and variation, for example, of thyroid disease or of heart disease could not be anticipated from an appraisal not including a physical examination and laboratory studies. This study brings out, as have other studies in the past, that a history of past illnesses without a physical examination may be misleading. This should be kept in mind when consideration is given to health planning at the community level. What one community needs in health services may not especially be needed in the next. Insofar as possible health planning should be tailored to the particular community.

Studies such as these reported by Chick et al are of distinct value. There are many residents of "hollows" in West Virginia, and for that matter in the entire Appalachian Region, and its borders. It is to be hoped that further studies of this nature will be made and reported in the near future.

MIGHT DOES NOT MAKE RIGHT

The story is told that after Harvey demonstrated the circulation of the blood the French Parliament or Chamber of Deputies, in anti-British exasperation, passed a law that the blood did not circulate.

Down through the ages men have continued to try to accomplish by law or edict that which was not right or acceptable by reasoning people and reasonable processes. Charlatans and others have sought medical recognition by way of diploma mills and falsified certificates.

Accomplishment by way of influence, either appointment to office, to hospital staffs, or club memberships has become a practice well recognized if not considered in the best taste.

Accomplishment by strikes, marches, riots and even planned executions have become commonplace in our time.

We as an enlightened and educated minority can, if we will, stand up and be counted as opposed to such tactics, and show ourselves to be on the side of right. Might does not make right and most of us know it.

Expressing our reasoned opinions and hopes to our elected representatives in the Legislature, local, state, and federal, is our right, privilege, and, yes, duty; but enforcing our personal desires by bribery, threat or strikes of whatever kind should not be condoned by right-thinking people.

We have seen examples of minority groups trying to attain status by legislation which they have not attained by education. We had, during the recent session of the Legislature, the strike of miners pressuring for hurried and questionable legislation. We have had a sit-down in our Capitol of workers discharged for neglect of their duties who are trying to obtain through nuisance value what they did not earn by the accomplishment of duty and good behavior.

May we doctors take our stand for what is right and try to be sure what is right before we go ahead. Let us be sure *what* is right and not *who* is right.

AMA CONVENTION IN NEW YORK CITY

That refreshing summer event—the Annual Convention of the American Medical Association—comes slightly later than usual this year. But once again the "AMA Annual" should figure significantly in advance planning of physicians.

The Annual Convention of course is the largest of the many meetings sponsored annually by the AMA. It covers so much of professional interest, and attracts so many physicians, members of allied health professions, industrial exhibitors, and guests, that only a relatively few cities have ample facilities to accommodate it.

This year's Annual Convention will be in the nation's largest city. Because the dates are July 13 through 17, it might be well to add that New York also ranks prominently in extent of air conditioning. But the Empire State's weather can be pleasant in July, and New York City also can benefit from any cool ocean breezes.

For the many physicians who take their families to the AMA Annual Convention, the New York City area obviously offers many and varied attractions.

There is no question about the benefits for the physician. Among other things, there is opportunity to ask questions, discuss techniques and developments with experts, and enter into dialogue which no other means of medical communication allows so extensively and instantaneously.

Four general scientific meetings are offered, as well as 23 section programs (with the Section on Special Topics offering six sessions), breakfast roundtables and fireside conferences.

Additional postgraduate education is available through the exhibits, medical motion pictures and scientific television presentations.

This might be an excellent time—not a moment too soon—to put down those dates (July 13 through 17) on your calendar, talk to the family about going to New York together, and start planning reservations and other details. The American Medical Association's 118th Annual Convention will be here before you know it!

Men in Nursing

There should be more male nurses. There should also be more female nurses. However, since the potential for the supply of female nurses has been developed to the maximum, and since there is still a serious shortage of nurses, *Hospitals,* The Journal of the American Hospital Association, is advocating an immediate widespread and all inclusive drive for the enlistment and training of male nurses.

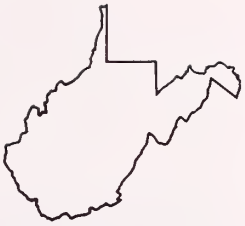
"The percentage of female high school graduates who enter nursing schools has been declining steadily, from 6.1 per cent in 1956 to 4.6 percent in 1966." The Public Health Service estimates that by 1975, one million nurses will be required—necessitating an admission rate of almost nine per cent of the female high school graduates in 1974.

Men make good nurses, as is proven by the great numbers in the medical departments of the armed services, and by the few male nurses who have been trained and are now serving in civilian hospitals.

Entrance into nursing by young men is hindered to some extent by the impression that it is a woman's job, which opinion may be and is being corrected. A large hindrance is the fact that not enough nursing schools accept men for training and some of those schools which do are limited in numbers due to the problems of co-education in such circumstances. . . .

Financial remuneration in the nursing profession is improving. Certainly any young person should find ample outlet in nursing for humaitarian endeavors. Once the "for women only" characterization has been removed, nursing should have many dedicated male adherents. Everything possible should be done now to encourage young men in this calling.—*The Journal of the Indiana State Medical Association.*

GENERAL NEWS



Drs. Ferguson and Sinclair-Smith To Speak at Annual Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.

A. B. Ferguson, Jr., M. D.

B. C. Sinclair-Smith, M. D.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Dr. Albert B. Ferguson, Jr., of Pittsburgh, and Dr. Bruce C. Sinclair-Smith of Nashville, Tennessee, will present papers during the three-day meeting.

Albert B. Ferguson, Jr., M. D.

Dr. Albert B. Ferguson, Jr., Professor and Chairman of the Department of Orthopedic Surgery at the University of Pittsburgh School of Medicine, will appear as a speaker at the first general scientific session on Thursday morning, August 21.

Doctor Ferguson, a native of New York City, was graduated from Dartmouth College and received his M. D. degree in 1943 from Harvard Medical School. He interned at Children's Hospital and Peter Bent Brigham Hospital in Boston, and served residencies at those Hospitals as well as Massachusetts General Hospital. He served with the Medical Corps of the United States Marines, 1944-46.

He was a member of the faculty at Harvard Medical School prior to accepting his present position. Doctor Ferguson is certified by the American Board of Orthopedic Surgery and is a member of the American College of Surgeons. He is a member of the American Academy of Orthopedic Surgery, the American Orthopaedic Association, the American Association for Advancement of Science, and the New York Academy of Science.

He is a member of the Allegheny County Medical Society and the Pennsylvania Medical Society, and he serves as Orthopedic Surgeon for the Pittsburgh Pirates Baseball Club.

Bruce C. Sinclair-Smith, M. D.

Dr. Bruce C. Sinclair-Smith, Associate Professor of Medicine at Vanderbilt University School of Medicine, will appear as a speaker at the third general scientific session on Saturday morning, August 23. The session will be devoted to a Symposium on "Cardio-Respiratory Emergencies and Their Management." Also participating in the program will be a surgeon and an anesthesiologist.

A native of Australia, Doctor Sinclair-Smith received M. B. and B. S. degrees from the University of Sydney. He served with the Royal Australian Army Medical Corps, 1944-47, as a Fellow at Johns Hopkins University Hospital in Baltimore, 1947-49, as a resident at the National Heart Hospital in London, 1949-51, and as a member of the faculty at the University of Sydney prior to joining the faculty at Vanderbilt.

He is a Fellow of the American College of Physicians, the Royal Australian College of Physicians and the Royal Edinburgh College of Physicians.

Gov. Moore and Dr. Dorman Honor Guests

Doctor Stark announced previously that the Hon. Arch A. Moore, Jr., Governor of the State of West Virginia, and Dr. Gerald D. Dorman of New York City, who will be installed as President of the American Medical Association in July, have accepted invitations to appear as honor guests at the meeting.

Governor Moore will deliver an address at the opening of the first general scientific session on Thursday morning, August 21, and Doctor Dorman will speak at the first session of the House of Delegates on Wednesday afternoon, August 20.

Members of the Auxiliary and other guests attending the meeting at The Greenbrier are cordially invited to listen to the addresses by Governor Moore and Doctor Dorman.

Dr. Richard W. Corbitt of Parkersburg, President of the State Medical Association, will deliver his Presidential Address at the final session of the House of Delegates on Saturday afternoon, August 23.

Additional Speakers Named

The names of several other speakers were announced previously. They are:

Dr. Emanuel M. Papper, Professor and Chairman of the Department of Anesthesiology, College of Physicians and Surgeons of Columbia University, New York City.

Maj. Gen. Joe M. Blumberg (MC), Commanding Officer of the United States Army Medical Research and Development Command, Washington, D. C.

Dr. Kermit E. Krantz, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center.

Dr. Raymond J. Jackman, Head of the Section of Proctology at the Mayo Clinic, Rochester, Minnesota.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Issue in August.

Ob.-Gyn. Society Conducts Travel Meeting

The West Virginia Obstetrical and Gynecological Society held its Annual Travel Meeting at Wilson Lodge, Oglebay Park, Wheeling, March 21-22.

Scientific sessions were held on Friday and on Saturday morning with several out-of-state physicians joining with West Virginia specialists in presenting the program.

Following the final scientific session, there was a business meeting with Dr. Robert Greco of Morgantown, President of the Society, presiding.

Looking Back 10 Years . . .

Dr. Joseph T. Mallamo of Fairmont (left) won the Medical Golf Tournament during the State Medical Association's Annual Meeting of 1959 and is shown accepting the trophy from Dr. Robert S. Wilson of Clarksburg, Chairman of the Golf Committee.

ACP Lists Final PG Courses For 1968-69

Four postgraduate courses in June will be the final ones in the series sponsored by the American College of Physicians during 1968-69.

Tuition fees for each course include $60 for members of the ACP and $100 for nonmembers.

The June schedule is as follows:

June 9-13—"Internal Medicine: Clinical Application of Current Concepts." University of Cincinnati Medical Center, Cincinnati.

June 11-14—"Neurology and the Internist," Bowman Gray School of Medicine, Winston-Salem, North Carolina.

June 16-20—"Hematology for Internists with Emphasis on Recent Advances," University of Rochester School of Medicine, Rochester, New York.

June 23-26—"Valvular Heart Disease, the Basis for Selecting Treatment," University of Oregon Medical School, Portland, Oregon.

Additional information about these courses may be obtained by writing to: Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Top Staff Appointments Announced by AMA

The appointment of Dr. Ernest B. Howard as Executive Vice President of the American Medical Association was announced recently by the AMA Board of Trustees.

Doctor Howard had been serving as Acting Executive Vice President since Dr. F. J. L. Blasingame left the employ of the AMA several months ago. Prior to that, Doctor Howard was Assistant Executive Vice President for a number of years.

Two top-level staff appointments were announced by Doctor Howard.

Mr. Jim Reed, Director of the Communications Division for the past eight years, becomes an Assistant to the Executive Vice President.

Mr. Charles S. Lauer, Director of the AMA Advertising Department since 1964, was appointed to succeed Mr. Reed as Director of the Communications Division.

Mr. Reed, 53, joined the AMA staff 11 years ago as the first editor of *The AMA News*, the Association's weekly medical newspaper. He will be one of two Assistants to the Executive Vice President. The other is Mr. Leo E. Brown, who has held that title since 1961.

As Director of the Communications Division, Mr. Lauer, 38, will exercise supervision over *The AMA News*, *Today's Health* magazine, the weekly Medical News section of *The Journal of the American Medical Association*, and the departments for radio, television and motion pictures; magazine relations; press relations; editorial services; and program services, including pamphlets, displays and other publications.

Charles D. Holland Is Named Acting RMP Director

Mr. Charles D. Holland of Morgantown has been named Acting Director of the West Virginia Regional Medical Program for Heart, Cancer, Stroke and Related Diseases.

The RMP Executive Committee named Mr. Holland to direct the program while a search is conducted for a new permanent director to succeed Dr. Charles L. Wilbar, Jr., who died earlier this year. Mr. Holland had served as Assistant Director under Doctor Wilbar.

Prior to October, 1967, when he joined RMP, Mr. Holland was Administrator of Appalachian Regional Hospital in Beckley. He is a Fellow of the American College of Hospital Administrators.

A committee has been designated to search for a permanent successor to Doctor Wilbar. Dr. Robert J. Marshall, Professor of Medicine at the West Virginia University School of Medicine, is Chairman of the committee.

Other members are: Dr. Vernon E. Duckwall of Elkins; Mr. William R. Huff of Charleston, Executive Vice President of the West Virginia Hospital Association; Dr. J. L. Mangus of Charleston; Mr. James H. Neale; Mr. William A. Nichols of Charleston, Executive Director of the West Virginia Division, American Cancer Society; Dr. Maynard P. Pride of Morgantown, President Elect of the West Virginia State Medical Association; Miss Juliann Ritter, Executive Director of the West Virginia Nurses Association; Dr. Harold Selinger of Charleston; and Dr. Herbert E. Warden of Morgantown.

Drug Company Executive Named Recipient of Award

The Passano Foundation, Inc., of Baltimore has named George H. Hitchings, Ph.D., of Yonkers, New York, as recipient of the $7,500 Passano Award for 1969.

Doctor Hitchings, Vice President in charge of research at Burroughs Wellcome and Company, was cited for his leadership in the rational application of the antimetabolite concept, in conjunction with exploration of differences in the enzymatic machinery of host and parasite, to the design of clinically important chemotherapeutic agents for immunosuppression and for therapy of leukemia, gout and malaria.

The Passano Foundation is a non-profit Maryland corporation which encourages medical science and research, particularly that having a clinical application. The award is given each year to an American citizen who has recently made an outstanding contribution to the advancement of medical science. Six of the 29 previous recipients have subsequently won the Nobel prize.

Doctor Hitchings received the award on April 14 at a dinner in Atlantic City, New Jersey, during the annual convention of the Federation of American Societies for Experimental Biology.

Dr. M. H. Porterfield Observes 50th Year of Medicine

Dr. Marvin H. Porterfield observed the 50th anniversary of his medical practice in Martinsburg in February.

Members of the Eastern Panhandle Medical Society and their wives observed the occasion with a testimonial dinner at the Martinsburg Country Club.

Marvin H. Porterfield, M. D.

Doctor Porterfield was born in Martinsburg in 1895, attended Shepherd College and received his M. D. degree in 1917 from the University of Maryland Medical School.

After interning at Franklin Square Hospital in Baltimore, Doctor Porterfield served in the Medical Corps of the United States Army during World War I. He later served in the Medical Corps of the United States Navy during World War II and the Korean War. He was discharged from the Navy in 1955 with the rank of Captain.

Doctor Porterfield served several terms as President and Secretary of the Eastern Panhandle Medical Society. He once served as Vice President and as a member of the Council of the West Virginia State Medical Association.

He has been married for 51 years to the former Katherine McLuckie of Frostburg, Maryland. They have three children.

10th Cardiovascular Symposium In Williamsburg, Virginia

The 10th Annual Cardiovascular Symposium will be held at the Williamsburg Lodge in Williamsburg, Virginia, September 5-7.

The program is sponsored by the American Heart Association's Council on Clinical Cardiology and the Tidewater Heart Association in cooperation with the Peninsula Heart Association.

Among the speakers will be Dr. Denton A. Cooley of Houston, Texas. Doctor Cooley will speak on "Clinical Application of Heart Transplantation."

Additional information may be obtained from the West Virginia Heart Association, 211 35th Street, S. E., Charleston, West Virginia 25304.

Transplant Registry Director Named

Dr. John J. Bergan of Chicago has been named Scientific Director of the American College of Surgeons-National Institutes of Health Organ Transplant Registry, which is housed at ACS headquarters in Chicago.

Doctor Bergan is Assistant Professor of Surgery at Northwestern University School of Medicine and Chief of the School's Transplantation Division.

Dr. Zimmermann Is Elected NSMR Director

Dr. Bernard Zimmermann of Morgantown is one of the four leaders in the field of bio-medical research and education to be elected in February to membership on the Board of Directors of the National Society for Medical Research.

Bernard Zimmermann, M. D.

The election came at a meeting of the NSMR National Council in Chicago on February 11. Doctor Zimmermann, Professor and Chairman of the Department of Surgery at the West Virginia University School of Medicine, was named to a four-year term on the Board.

Other directors elected are: Dr. Maurice B. Visscher, Chairman of the Department of Physiology at the University of Minnesota School of Medicine; Dr. Luther Terry, Vice President for Medical Affairs at the University of Pennsylvania; and Dr. Norman E. Shumway, Professor of Surgery at Stanford University.

Doctor Zimmermann, who has been at WVU since 1960, is known for research in a number of fields including endocrinology, diabetes, adrenal function and oncology.

Industrial Medical Assn. Lists Session in Weirton

The Annual Spring Scientific Meeting of the Industrial Medical Association of the Pittsburgh-Cleveland Area will be held on May 16 at the Weirton Steel Corporation in Weirton.

Dr. Miles O. Colwell of Pittsburgh, President of the Chapter, will preside at the morning session, when scientific papers will be presented.

After lunch, Dr. William B. Markley of Cleveland, President Elect, will preside at a business meeting. There will be a guided tour of the Weirton Steel Medical Department and of the "Mill of the Future."

Dr. Seigle W. Parks of Charleston is a Director and Past President of the Chapter.

Additional information about the meeting may be obtained by writing to Dr. A. M. Puleo, Secretary-Treasurer, Addressograph Multigraph Corporation, 1200 Babbitt Road, Cleveland, Ohio 44117.

SMA Meeting in Atlanta

The 63rd Annual Meeting of the Southern Medical Association will be held at Atlanta, Georgia, November 10-13.

Physicians interested in presenting or discussing a paper or sponsoring an exhibit should write to: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama.

Measles Rate in West Virginia Shows Decrease

The March 19, 1969 issue of the "State of the State's Health" featured an article on the rapid decrease in measles in West Virginia during the past three years. According to State Health Director N. H. Dyer, West Virginia reported 14,872 cases of measles in 1965, 5,580 cases of measles in 1966 (down 73.3 per cent from 1965), 1,486 cases of measles in 1967 (down 73.4 per cent from 1966), and 337 cases of measles in 1968 (down 77.3 per cent from 1967).

Doctor Dyer said the decline in measles is quite a tribute to the local health departments and the private physician. While no information concerning the amount of measles vaccine administered by local physicians is available, the local health departments have administered 125,510 doses of measles vaccine through December, 1968.

Studies have shown that, on a national basis, 95 per cent of the children have had measles by the time they are 12 years of age. Now that all children in the state must also be immunized against measles before entering school, plus the fact that 41,606 doses of measles vaccine were administered in the school-age population, one of the main groups of source and spread of measles is being curtailed.

In order to eradicate measles, Doctor Dyer said, we must now change our thoughts from impressive statistics to specific individuals that are still susceptible to measles. In addition, better reporting of measles will help us curtail the spread of measles in specific areas. The need for better reporting is so great, in fact, that it is generally accepted that only one in 10 cases of measles is recorded.

Good reporting of both rubeola and rubella will produce two effects. First, we will move closer to our objective of the eradication of rubeola by identifying the individual patient and his susceptible contacts. This will enable us to curtail the spread of measles through immunization. Secondly, by reporting all known cases of rubella (German) measles, we will be able to determine problem areas in West Virginia in anticipation of receiving German measles vaccine during the next fiscal year.

17th Annual Bluefield Seminar Next October 16

The 17th Annual Seminar sponsored by Bluefield Sanitarium and affiliated clinics will be held on Thursday, October 16, at the Bluefield Country Club.

Co-sponsors are the Stevens Clinic in Welch and The Clinch Valley Clinic in Richlands, Virginia.

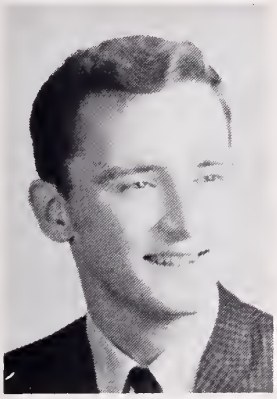
There will be a scientific session, social hour and dinner. The complete program will be published in a future issue of *The Journal.*

Much Blindness Can Be Prevented

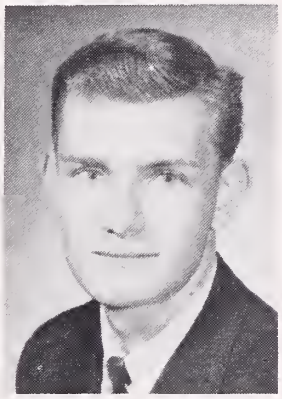
Half of all blindness due to disease, accident, neglect or ignorance can be prevented, according to the National Society for the Prevention of Blindness.

Two Young Men Are Awarded Medical Scholarships

Two young West Virginia men have been awarded four-year scholarships to the West Virginia University School of Medicine by the West Virginia State Medical Association.



John R. Hitt



Wilbur Z. Sine

Dr. Martha J. Coyner of Harrisville, Chairman of the Association's Committee on Medical Scholarships, identified this year's recipients as Wilbur Zinn Sine, 21, of Hundred, Wetzel County, and John R. Hitt, 26, of Richwood. Both have been accepted by the School of Medicine as first-year students beginning next fall.

They will receive $1,000 apiece for each of their four years at the School of Medicine for a total of $4,000 each. Sine and Hitt are the nineteenth and twentieth deserving students to be awarded scholarships since the program was undertaken several years ago.

Sine, a native of Hundred, attended Hundred High School and received his B.S. degree earlier this year at Fairmont State College. He is a son of Mrs. Arnold A. Sine of Hundred and the late Mr. Sine.

A native of Charleston, Hitt was the son of the late Mr. and Mrs. Henry H. Hitt, Sr. He is a graduate of Richwood High School and now attends Marshall University.

Hitt served three years in the U.S. Army, including 11 months with the U.S. First Infantry Division in Vietnam.

Huntington Physician Enrolls In Vietnam Program

Dr. Fernando Dominguez of Huntington was among a group of physicians who left the United States last month for a two-month tour of volunteer service under the "Volunteer Physicians for Vietnam" program.

The program, under which doctors spend two months without pay treating civilians in Vietnam, is sponsored by the American Medical Association and the Agency for International Development. In order to maintain the program at its current strength, 32 physicians must be recruited every 60 days.

By-Laws Committee Is Named For Hospital Council

A temporary Committee on Constitution and By-Laws for the Joint Council on Teaching Hospitals has been appointed by Dr. David Z. Morgan of Morgantown, Chairman Pro Tempore of the Council.

Doctor Morgan named the following persons to serve on the Committee: Mr. Joseph E. Peery, Jr., of Welch, Administrator of Stevens Clinic Hospital and President of the West Virginia Hospital Association; Mr. William R. Huff of Charleston, Executive Vice President of the West Virginia Hospital Association; Dr. Pat A. Tuckwiller of Charleston, Chairman of the State Medical Association's Committee on Medical Education and Hospitals; Dr. Forest A. Cornwell of Beckley, Chief of Pediatrics at Appalachian Regional Hospital; and Doctor Morgan.

The Council, sponsored by the West Virginia Hospital Association and West Virginia State Medical Association, held its first organizational meeting in Charleston on March 13. Doctor Morgan said he hoped to call a meeting of the Committee on Constitution and By-Laws prior to the next meeting of the Council, which will be held in Charleston on Thursday, May 22.

Initially, the Council will be composed of two representatives from each West Virginia hospital which maintains one or more approved internship or residency programs; three representatives of the Hospital Association; three representatives of the Medical Association; and one representative of the West Virginia University School of Medicine.

Dr. David Z. Morgan of Morgantown (right) is shown after his election as Chairman Pro Tempore of the West Virginia State Medical and Hospital Associations' Joint Council on Teaching Hospitals, which held its first organizational meeting in Charleston on March 13. With Doctor Morgan are: Dr. Richard W. Corbitt of Parkersburg (left), President of the State Medical Association; and Mr. Joseph E. Peery, Jr., of Welch, President of the Hospital Association.

Drugs Down, Commodities Up

Wholesale prescription drug prices have declined 14 per cent in the past 17 years while wholesale prices of all commodities measured by the U.S. Bureau of Labor Statistics have risen 31 per cent, according to the Pharmaceutical Manufacturers Association.

New Association Members

Dr. Walter A. Bonney, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Bonney, a native of Enterprise, Mississippi, was graduated from the University of Alabama and received his M. D. degree in 1954 from the Columbia University College of Physicians and Surgeons. He interned at Western Reserve Hospital and served a residency at Columbia-Presbyterian Medical Center. He served as a Captain with the Medical Corps of the United States Marine Corps, 1956-58, and he previously served on the faculty at Vanderbilt University School of Medicine. He is currently serving as Professor and Chairman of the Department of Obstetrics and Gynecology at the WVU School of Medicine.

* * * *

Dr. George Y. Ching, Spencer State Hospital, Spencer (Parkersburg Academy). Doctor Ching, a native of Hawaii, was graduated from the University of Hawaii and received his M.D. degree in 1936 from St. John's University in Shanghai, China. He interned at St. Luke's Hospital in Shanghai and served a residency at Hawaii State Hospital. He was previously located in Hong Kong and his specialty is psychiatry.

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Dr. Donald C. Dickenson, WVU Health Service, Morgantown (Monongalia). Doctor Dickenson, a native of Bluefield, was graduated from West Virginia University and received his M. D. degree in 1963 from the WVU School of Medicine. He interned at North Wheeling Hospital and served with the United States Air Force. He is engaged in general practice.

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Dr. Gerardo Gonzalez, Colin Anderson Center, St. Marys (Parkersburg Academy). Doctor Gonzalez, a native of Cuba, received his M. D. degree in 1953 from the University of Havana. He interned and served a residency at the Caliyto Garcia Hospital in Havana.

* * * *

Dr. James T. Hughes, 305 North Church Street, Ripley (Kanawha). Doctor Hughes, a native of Spencer, was graduated from West Virginia University and received his M.D. degree in 1960 from Jefferson Medical College. He interned at Philadelphia General Hospital and served residencies at that hospital and West Virginia University Hospital. He served for 2½ years with the Medical Corps of the United States Navy. His specialty is internal medicine.

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Dr. Eladio E. Mazon, Colin Anderson Center, St. Marys (Parkersburg Academy). Doctor Mazon, a native of Cuba, received his M. D. degree in 1945 from the University of Havana. He interned at Emergency Hospital in Havana and served residencies at the Civil Hospital in Havana and Kanawha Valley Hospital in Charleston. He is engaged in general practice.

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Dr. Louis C. Palmer, 147 W. Main Street, Bridgeport (Harrison). Doctor Palmer, a native of Clarksburg, was graduated from West Virginia University and received his M. D. degree in 1957 from the WVU School of Medicine. He interned at Harrisburg Polyclinic Hospital in Harrisburg, Pennsylvania, and served with the West Virginia National Guard for six years. He is engaged in general practice.

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Dr. Richard C. Rashid, Thomas Hospital, South Charleston (Kanawha). Doctor Rashid, a native of Montgomery, was graduated from West Virginia University and received his M. D. degree in 1962 from the Medical College of Virginia. He interned at Mercer Hospital in Springfield, Ohio, and served a residency at Lakeside Hospital in Cleveland. He served as a Lieutenant in the Medical Corps of the United States Navy, 1963-65, and his specialty is ophthalmology.

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Dr. Tom A. Skansi, 717 Glen Ridge Road, Charleston (Kanawha). Doctor Skansi, a native of Yugoslavia, received his M. D. degree from the Zagreb University School of Medicine. He interned at Charleston Memorial Hospital, 1966-67, and he is engaged in general practice.

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Dr. Elisa N. Tan, Appalachian Regional Hospital, Man (Logan). Doctor Tan, a native of the Philippines, received her M. D. degree in 1962 from the University of the East Ramon Magsaysay. She interned at St. Francis Hospital in New York City, and also served residencies at Lenox Hill and St. Luke's Hospitals in that city. Her specialty is anesthesiology.

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Dr. Manuel Tayko, Wyoming General Hospital, Mullens (Wyoming). Doctor Tayko, a native of the Philippines, received his M. D. degree in 1957 from the University of Santo Tomas. He interned at St. Luke's Hospital in Cedar Rapids, Iowa, and served a residency at Washington Hospital Center in Washington, D. C. His specialty is general surgery.

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Dr. O. Lee Trick, WVU Medical Center, Morgantown (Monongalia). Doctor Trick, a native of Anderson, Indiana, was graduated from Indiana University and received his M. D. degree in 1958 from the Indiana University School of Medicine. He interned at Blodgett Memorial Hospital in Grand Rapids, Michigan, and served a residency at Duke University. He was previously located in Albuquerque, New Mexico, and his specialty is psychiatry.

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Dr. Walter E. Williamson, Jr., 204 Prunty Building, Clarksburg (Harrison). Doctor Williamson, a native of St. Louis, was graduated from Baylor University and received his M. D. degree in 1956 from the Baylor University College of Medicine. He interned at the United States Public Health Service Hospital in New Orleans and served residencies at that hospital, Tulane University and Temple University. He was previously located at the University Public Health Hospital in Detroit, and his specialty is general surgery.

ENT Course in Morgantown May 15-17

A course entitled "Otolaryngology for Primary Physicians" will be conducted at the West Virginia University School of Medicine in Morgantown, May 15-17.

Philip Sprinkle, M. D.

William C. Morgan, Jr., M. D.

The course is sponsored by the Division of Otolaryngology at the Medical Center and is supported by the West Virginia Regional Medical Program.

Thursday Morning Session

Drs. Philip M. Sprinkle, Professor and Chairman of the Division, and Richard Chamberlain will give the introduction and present the course objectives on Thursday morning, May 15. The remainder of the Thursday morning program will be as follows:

"Salivary Gland Disease"—Philip M. Sprinkle, M. D.

"Medical Aspects and Indications for Surgery in Sinusitis"—Carl H. Cather, Jr., M.D., of Morgantown, Clinical Assistant Professor of Surgery, WVU.

"Surgery for Hearing in Otosclerosis"—William C. Morgan, Jr., M.D., Otologist, Eye and Ear Clinic of Charleston.

"Tumors of the Eye and Orbit"—Robert R. Trotter, M.D., Professor and Chairman, Division of Ophthalmology, WVU.

A luncheon and round table discussions will follow the morning session.

Thursday Afternoon Program

The program for Thursday afternoon, May 15, will be as follows:

"The Differential Diagnosis of Vertigo"— T. F. Hall, Jr., M.D., Resident in Otolaryngology, WVU.

"The Differential Diagnosis of Oral Cavity Lesions" John Welch, D. D. S., Associate Professor of Oral Surgery, WVU.

"Otological Dermatology"—Ed Thompson, M. D.

"Indications for Tonsillectomy and Adenoidectomy"—Phillip B. Mathias, M. D.

"Dermoid Cyst of the Nose (Film)"—Philip M. Sprinkle, M. D.

"Lymphomas of the Head and Neck"—John Harley, M. D., Assistant Professor of Medicine, WVU.

"Coagulation Problems in ENT"—Earl Campbell, M. D.

Friday Program

Papers will be presented Friday morning, May 16, and a wet clinic will follow after lunch and round table discussions. The lecture program is as follows:

"Trauma of the Eye and Orbit"—Robert R. Trotter, M. D.

"Surgery for Hearing in Chronic Otitis Media"—William C. Morgan, Jr., M. D.

"Tumors of the External and Middle Ear"—Sherman E. Hatfield, M. D., Otolaryngologist, Charleston.

"Surgery of the Thyroid Gland"—Richard A. Currie, M. D., Associate Professor of Surgery, WVU.

"Signs and Symptoms of Head and Neck Lesions" —Romeo Y. Lim, M. D., Otolaryngologist, Charleston.

"Facial Fractures"—A. Parke Avery, M. D., Resident in Otolaryngology, WVU.

"Carcinoma of the Nose (Film)"—Philip M. Sprinkle, M. D.

"Carcinoma of the Tongue and Tonsil"—T. F. Hall, M. D.

"Combined Therapy of Radiation and Surgery"—Fred D. Owens, M. D., Resident in Otolaryngology, WVU.

Saturday Morning Program

Additional papers will be presented Saturday morning, May 17, and will be as follows:

"Laryngeal Injuries"—Fred D. Owens, M. D.

"Lesions of the Larynx" (Film and Discussion)—James Spencer, M. D., Otolaryngologist, Charleston.

"Speech Pathology for the Primary Physician"—Glen P. McCormick, Ph. D., Professor of Speech Pathology and Audiology, WVU.

"Ethics of Hearing Testing and Hearing Aid Evaluation"—Glen P. McCormick, Ph. D., and Wilnert E. Rankin, M.S., Assistant Professor of Audiology.

"Tumors of the Eighth Nerve"—Fred D. Owens, M. D.

Additional information about the course may be obtained by contacting Dr. Philip M. Sprinkle, Division of Otolaryngology, WVU Medical Center, Morgantown.

12th Alumni Scientific Meeting At MCV, June 6

The 12th Annual Alumni Scientific Assembly will be held at the Medical College of Virginia in Richmond on June 6.

Dr. Kinloch Nelson, Dean of the School of Medicine, will give the address of welcome. The following papers will be presented:

"Drugs and Adolescents"—George Bright, M. D. Assistant Professor of Pediatrics.

"Current Trends in Cancer Surgery"—Walter Lawrence, Jr., M. D., Professor and Chairman, Division of Oncology.

"Clinical and Radiological Manifestations of Zollinger-Ellison Syndrome"—Robert Armstrong, M. D., Professor of Radiology, and Z. Reno Vlahcevic, M. D., Assistant Professor of Medicine.

"Newer Concepts of Gout and Hyperuricemia"—Duncan S. Owen, Jr., M.D., Assistant Professor of Medicine.

"Advances in Neurosurgery"—John F. Alksne, M. D., Professor and Chairman, Division of Neurological Surgery.

Additional information may be obtained by contacting: Dr. Charles M. Caravati, Director of Continuing Education, Medical College of Virginia School of Medicine, Richmond, Virginia.

Emergency Aid Course In Morgantown

A practical course on emergency aid and transportation of ill and injured persons will be held at the West Virginia University Medical Center in Morgantown, May 22-24, under the sponsorship of the Committee on Injuries of the American Academy of Orthopaedic Surgeons.

Justus C. Pickett, M. D.

The course has been arranged for ambulance attendants, nurses, policemen, firemen, safety engineers, volunteer rescue squads, and other persons involved in emergency aid.

Cooperating in the course are the Medical Center and the West Virginia Chapter, American College of Surgeons. Dr. Justus C. Pickett, Chairman of the Division of Orthopedic Surgery at WVU, organized the program and will direct the course.

"A fast ride by ambulance or other means has practically never saved a life," Doctor Pickett observed. "What is really needed is an emergency crew well schooled in preparing the injured for transport. This means being able to make a quick survey, to determine medical priority, and take the necessary life-saving measures."

Instructional personnel will include members of the faculty of the School of Medicine, members of the West Virginia State Medical Association, and others. They will speak and demonstrate on a wide range of subjects, including resuscitation, cardiac massage, splinting of fractures, burns and other medical emergencies.

The course is one of a series being conducted in series throughout the nation by the Academy's Committee on Injuries.

Members of the Program Committee for the Morgantown course in addition to Doctor Pickett are: Dr. N. W. B. Craythorne, Chairman of the Division of Anesthesiology at WVU; Dr. David Z. Morgan, Assistant Professor of Medicine; Dr. Thomas J. Tarnay, Assistant Professor of Surgery; and Richard C. Mullens, Morgantown Ambulance Service.

A registration fee of $50 will be charged, and additional information about the course may be obtained by writing to Doctor Pickett, 400 Drummond Street, Morgantown, West Virginia 26505.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

May 5-7—Am. Gyn. Soc., New Orleans.
May 5-9—Am. Psychiatric Assn., Miami Beach.
May 6-7—Assn. of Am. Phys., Atlantic City.
May 12-15—Am. Urological Assn., San Francisco.
May 12-16—Ohio Medical, Columbus.
May 24-26—Am. Thoracic Soc., Miami Beach.
May 26-28—Am. Oph. Soc., Hot Springs, Va.

June 9-11—Am. Neurological Assn., Los Angeles.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.

July 2-7—Int. Col. of Surg., Lake Placid, N. Y.
July 13-17—AMA, New York.
July 18-19—Rocky Mtn. Cancer Conference, Denver.

Aug. 18-21—Am. Hosp. Assn., Chicago.

Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.

The West Virginia Medical Journal

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Cancer Palliation by Solid Tumor Chemotherapy (Part I)

Alvin L. Watne, M. D.

The first cancer chemotherapy was the use of potassium arsenite, or Fowler's solution, by Lissauer[1] in 1865 for the treatment of leukemia. The basic principles of chemotherapy were set down by Ehrlich[2] who reported the first successful chemotherapy with a synthetic drug, curing trypanosomiasis in rodents with trypan red.

The Author

- **Alvin L. Watne, M. D., Professor of Surgery, Charleston Foundation Chair of Cancer Research, West Virginia University Medical Center, Morgantown.**

This is the first in a series of three articles by Doctor Watne which will be published in consecutive issues of The Journal.

The role of hormones in the growth and control of cancer dates back to the end of the 19th century with the empiric observations on the effect of castration in producing a regression of breast and prostatic cancer in man.[3,4] The "rational" basis of hormone therapy did not develop until the 1930's, with the demonstration of large amounts of "acid phosphatase" in the human prostate, prostatic tumors and the serum of patients with prostatic cancer.[5] Huggins'[6] fine work in this field resulted in a Nobel prize in 1966.

In the decade before World War II, a few chemotherapy drug development programs emerged. These included the study of aldehydes by Boyland,[7] in Great Britain, and of heptaldehydes by Strong.[8] World War II interrupted cancer research activities. Classified research, however, continued in many areas such as war gases, nutrition and antibiotics. An accident during the transport of mustard gas exposed several individuals to the material, with the resultant deficiency of cell elements of the blood.[9] After the war, the drug screening program set up by Shear[10] at the National Cancer Institute was expanded into the first interinstitutional collaborative chemotherapy program. Broadly based drug development programs were started at the Sloan-Kettering Institute for Cancer Research, the Chester Beatty Institute, the University of Toyko, and at the Children's Cancer Research Foundation where Farber[11] discovered that folic acid antagonists led to a spectacular, though temporary, remission in acute leukemia.

Over the past 20 years, many institutions and scientists have tested and evaluated thousands of drugs by sophisticated animal screens, and hundreds of drugs by controlled clinical studies. Such application of scientific knowledge and effort has brought about some astounding changes in cancer therapy, and has resulted in a new era of cancer palliation for patients with solid tumors not amenable to conventional surgery or radiotherapy.

Indications for Cancer Chemotherapy

No area in the present day treatment of cancer is as vague and ill-defined as the identification of the patient suitable for solid tumor chemotherapy. The physician is called upon to practice the art of medicine, while applying the ultimate of massive scientific effort in the patient's behalf. The possibility of charlatanism is always present unless the physician constantly holds the patient's needs foremost, and critically

evaluates his own therapy and results. Our indications for cancer chemotherapy are given in Table 1. The first and foremost indication is clinical evidence of incurable disease by any of the other available modalities such as surgery or radiotherapy. For solid tumors, such evidence will demand careful physical examination and laboratory studies, including liver function tests and x-ray examinations. It may be necessary to obtain a tissue diagnosis by biopsy. With the establishment of disease extending beyond the scope of conventional treatment, an informed, cooperative patient is a must for any successful chemotherapeutic program. If the patient cannot realistically face the disease and accept the proposed therapy, we will not treat the patient—which does not mean that the grim aspects of incurable cancer must be emphasized but, rather, that a therapy program is possible.

The art of tumor chemotherapy resembles a card game, wherein the maximum benefit should accrue from each card played. On this basis, we have obtained the most gratifying results from chemotherapy when the patient's disease has been progressive, and when it has resulted in symptoms and concern for the patient. When the symptom is pain, chemotherapy generally is ineffective in giving relief. Because of this, we often recommend some type of neurosurgical procedure or radiotherapy for pain relief, and then proceed with a chemotherapy program. The patient must carry a sufficiently favorable prognosis to justify the extensive treatment necessary. Our own experience has shown that patients in the very advanced stages of cancer respond less often and for a shorter period of time to the chemotherapy[12]. Patients who cannot take fluids and food orally, who have enteric fistulas, or chronic infections tolerate the drugs poorly. Moderately compromised liver function and kidney function are contraindications to chemotherapy. Brain metastases in general bode ill for any systemic chemotherapy program. There is no easy way to treat cancer, and an adequate chemotherapy program will demand as much from the patient as surgery or radiotherapy.

Table 1
Indications for Cancer Chemotherapy

1. Clinical evidence of incurable disease.
2. An informed, cooperative patient.
3. Progressive and/or symptomatic disease.
4. Adequate prognosis and clinical condition.
5. Reasonable hope of objective and/or subjective response.

Table 2
The Chemotherapy Regimen

1. Critical evaluation of patient's status.
2. Selection of drugs to meet disease and patient's requirements.
3. Adequate treatment.
4. Careful follow-up for toxicity and disease response.
5. Assume responsibility for maintenance therapy, additional therapy and supportive measures.

The last indication for cancer chemotherapy is a reasonable hope of an objective or subjective response for the patient. While the physician should not treat simply because the cancer is there, institution of some type of program, be it only supportive in nature without any antitumor drug whatsoever, will benefit most advanced cancer patients. Abandonment is the worst possible fate for the cancer victim, and judiciously applied chemotherapy aids both patient and physician in avoiding this tragedy.

The Chemotherapy Regimen

Establishment of a chemotherapy program involves time and thought on the part of the physician, and considerable effort and expense to the patient. In general, it is best accomplished by hospitalization of the patient during the initial evaluation. Our steps in the regimen are outlined in Table 2.

The primary step is the initial evaluation of the patient's status which, in addition to routine physical examination, demands confirmation of the primary disease and identification of the extent of spread. Demonstration of disseminated disease may entail extensive x-ray studies, liver function tests including radioisotope scans, renal function tests, endoscopic examinations and even surgical biopsy including celiotomy.

If the patient's prognosis is four to six months, and his physical condition will accept the chemotherapy demands, the physician can proceed to select an appropriate drug to meet the disease and the patient's needs. Many drugs are administered intravenously and demand frequent visits to the physician. If the patient's situation is such that he cannot travel readily, he could use an oral drug. Some patients are too unreliable to take an oral drug, in which case a parenteral route is preferred.

With selection of the drug, the physician must see that the patient receives an adequate course of therapy. It is at this point that an informed and cooperative patient is important. Frequently, the early nausea and vomiting induced by the drug will make the patient desire to stop therapy. The physician may limit his therapy in order to avoid such upset patients. While Bross[13] has shown that host response is not necessarily associated with drug toxicity, we have observed that there is a minimal dose and time under which no response can be anticipated.

Once treatment is begun, the physician must observe the patient closely for drug toxicity, and he must carefully evaluate any objective or subjective response. For this reason, nodules and masses must be measured before treatment so that some baseline can be established. While it may not be important whether the mass decreased 30 per cent or 90 per cent in size, the physician and patient must be able to recognize the lack of therapeutic response and the presence of progressive disease. If tumor regression does occur, the onset of tumor regrowth must be identified. On these indications, therapy can be adjusted or other drugs and therapy considered.

We feel that any physician who enters into a chemotherapy program with a cancer patient takes upon himself responsibility for the patient's continued therapy, including maintenance programs with the drugs, additional chemotherapy, surgery or radiotherapy, and any other supportive measures indicated. It is a small but definite solace to the cancer patient and his family to know that the physician will utilize every resource at his disposal for the patient's palliation and continued comfort. This does not imply any attempt at prolongation of a miserable existence for the patient but, rather, an effort to provide him with a comfortable life during his allotted days. I seriously doubt that any physician can materially prolong a cancer patient's terminal episode by any heroic measure, nor can he effectively shorten this period by any amount of intentional or unintentional neglect.

Table 3
Solid Tumor Chemotherapy
Alkylating Agents

Mechlorethamine HCL (HN_2, Mustargen)	I.V.	0.4 mg./kg. Sing. or Div.
Triethylenethiophosphoramide (TSPA, Thiotepa)	I.V.	0.2 mg./kg. x 5
	I.M.	45-60 mg. x 1
	I-VES	30-120 mg. x 4
Cyclophosphamide (Cytoxan, Endoxan)	I.V.	3.5-5.0 mg./kg. 10
		40-60 mg./kg. x 1
	Oral	50-300 mg./day
Chlorambucil (Leukeran)	Oral	0.1-0.2 mg./kg./day Main. 0.03-0.1 mg./kg.
L-Phenylalanine Mustard (Alkeran, Melphalan, L-Sarcolysin)	Oral	6-10 mg./day Main. 2-4 mg./day
Triethylenemelamine (TEM)	Oral	2.5-5.0 mg. 2 x wk.
	I.A.	0.03 mg./kg./day

Antimethabolites

Methotrexate (Amethopterin)	Oral	2.5-5.0 mg./day
	I.M.	10-30 mg./day x 5
	I.V.	1.5-5.0 mg./day
	I.A.	25-50 mg./day with Leucovorin
5-Fluorouracil (5-FU, Fluorouracil)	I.V.	12 mg./kg. x 5
		6 mg./kg. x 2 days
	Topical	20% Oint. x 30 days
Hydroxyurea (Hydrea)	Oral	80 mg./kg.q. 3 days or 20-30 mg./kg./day

Miscellaneous Drugs

DRUG	ROUTE	DOSAGES
Actinomycin D (Dactinomycin, Cosmegen)	I.V.	0.015 mg./kg. x 5 0.05 mg./kg./wk.
Vincristine Sulfate (Oncovin, LCR, VCR)	I.V.	0.03-0.075 mg./kg./wk.
Quinacrine HCL (Atabrine)	Intra-Cavitary	50-800 mg. x 5

Hormonal Agents

Androgen		
Testosterone Propionate	I.M.	50-100 mg. 3 x wk.
Fluoxymesterone (Halotestin)	Oral	10-30 mg./day
Estrogen		
Diethylstilbesterol	Oral	15 mg./day
Ethinyl Estradiol (Estinyl)	Oral	0.1-1.0 mg. 3 x day
Chlorotrianisene (Tace)	Oral	12-25 mg./day
Progestin		
Hydroxyprogesterone Caproate (Delalutin)	I.M.	1 gm. 2 x wk.
Thyroid		
Desiccated Thyroid	Oral	60-180 mg./day
L-Triiodothyronine (Cytomel, T3)	Oral	25-100 mcg./day
L-Thyroxine (Synthroid, T4)	Oral	0.1-0.3 mg./day

Drugs for Solid Tumor Chemotherapy

Table 3 lists the drugs currently available commercially that are in general use for the treatment of various solid tumors. The recommended route of administration and dosage schedule are those frequently used by us, but do not imply that this is the only treatment schedule of value. A scholarly review of these drugs, their development and mode of action is given in the comprehensive review by Hall.[14] Nitrogen mustard was one of the original alkylating agents,[15] and has remained a mainstay in the field. The oral preparations of cyclophosphamide and chlorambucil are additional alkylating agents effective in solid tumor chemotherapy.

The antimetabolite Methotrexate was developed from Farber's[11] pioneer work with folic acid antagonists. It has wide application by various routes of administration in solid tumor chemotherapy. 5-fluorouracil represents the result of a concentrated effort to develop antimetabolites that would interfere with pyrimidine synthesis.[16] Hydroxyurea was synthesized in 1869 by Dresler and Stein.[17] It recently has been introduced into cancer chemotherapy[18]. It holds promise in melanoma and in association with x-ray therapy in squamous cell carcinoma.

The actinomycins were described by Waksman et al, [19] in 1955. Their toxicity prohibited their use as antibacterial agents. Farber et al[20] gave an early evaluation of actinomycin D in the treatment of human cancer. It is a toxic drug

but has found useful application as an adjunct to surgery and irradiation.

Vincristine was originally extracted from the periwinkle plant (Vinca rosea Linn.) and was know as Leurocristine.[21] It represents a group of plant alkaloids that have been found to be active against various tumors. Quinacrine was tested for its antitumor activity by the National Cancer Institute, in 1946.[22] It remained for Gellhorn[23] to demonstrate the value of this drug in malignant effusions.

The hormonal agents have been applied to the control of malignant growths after Huggins' original observations. Numerous compounds are available and effective. These represent some of the more commonly used agents and, in general, represent our choice if hormonal control is indicated.

Table 4
Drug Toxicity

Toxicity	*Rx*
Gastrointestinal	
Nausea and Vomiting	Chlorpromazine Barbiturates Rx at Night Divide or ▼ Drug
Stomatitis	Stop or ▼ Drug Oral Lozenges I. V. Fluids
Diarrhea	Stop or ▼ Drug Kaopectate, Lomotil Tinc. Opium I. V. Fluids
Hematological	
Leukopenia Thrombocytopenia Anemia	Stop or ▼ Drug Whole Blood (Fresh) Isolation Antibiotics Hydrocortisone
Other	
Alopecia Hemorr. Cystitis Areflexia Skin Rash Paralytic Ileus Mental Aberr.	Stop or ▼ Drug Supportive

Toxicity of Anticancer Drugs

All of the currently available anticancer drugs are toxic. The search for a drug with specific tumor activity has been constant. Perhaps the arduous search will pay off with the new drug 1-asparaginase.[24] Until such a nontoxic drug becomes available, the clinician must alert himself to the signs and symptoms of toxicity in his patient, and take the appropriate corrective measures. As occurs in every clinical situation, each cancer patient will have his own individual "happening" with this drug. Various toxic manifestations may occur, and these are listed in Table 4, along with our usual measures taken to counteract the toxicity.

Gastrointestional symptoms frequently develop early in the course of therapy, often immediately after administration of the drug. The physician must be alert to the insidious development of dehydration, electrolyte imbalance and poor nutrition from these toxic manifestations. Frequently the development of stomatitis indicates a marked inhibition of cell replication and will be a forerunner of a serious bone marrow depression. This frequently occurs with 5-fluorouracil administration and, while the peripheral blood count may be normal, we use stomatitis as an indication to withhold the drug for a few days to observe a beginning drop in the leukocytes. Often the first manifestation of the impending leukopenia will be a decrease in the total neutrophil count. While we use a white blood cell count of 3000 cells/mm^3 as a critical level below which we administer no drug, the important guide for the physician is the relative change in the neutrophil, total leukocyte and platelet count. A steady decrease can indicate impending deficiency. Treatment must be prompt and vigorous. Fresh whole blood is most valuable, as is isolation of the patient to avoid superimposed infection. We use appropriate antibiotics only when the infectious agent is identified and the drug sensitivity established. Prophylactic antibiotics have resulted in resistant infections and disaster. Steriods are indicated only in the extreme situations, being of value in supporting vital body functions. Our own experience has not shown that cortisone enhances the bone marrow production of blood cells. The other toxic manifestations are less frequent, and are treated best by stopping or decreasing the drug dosage. Alopecia is fairly frequent with cyclophosphamide and 5-fluorouracil. Hemorrhage cystitis may arise from cyclophosphamide administration. Areflexia and paralytic ileus may occur with extreme toxicity and are a frequent manifestation with vincristine. A skin rash occasionally is seen with actinomycin D and with 5-fluorouracil. Mental aberrations occur with severe toxicity and may vary from disturbing dreams to coma.

(To Be Continued)

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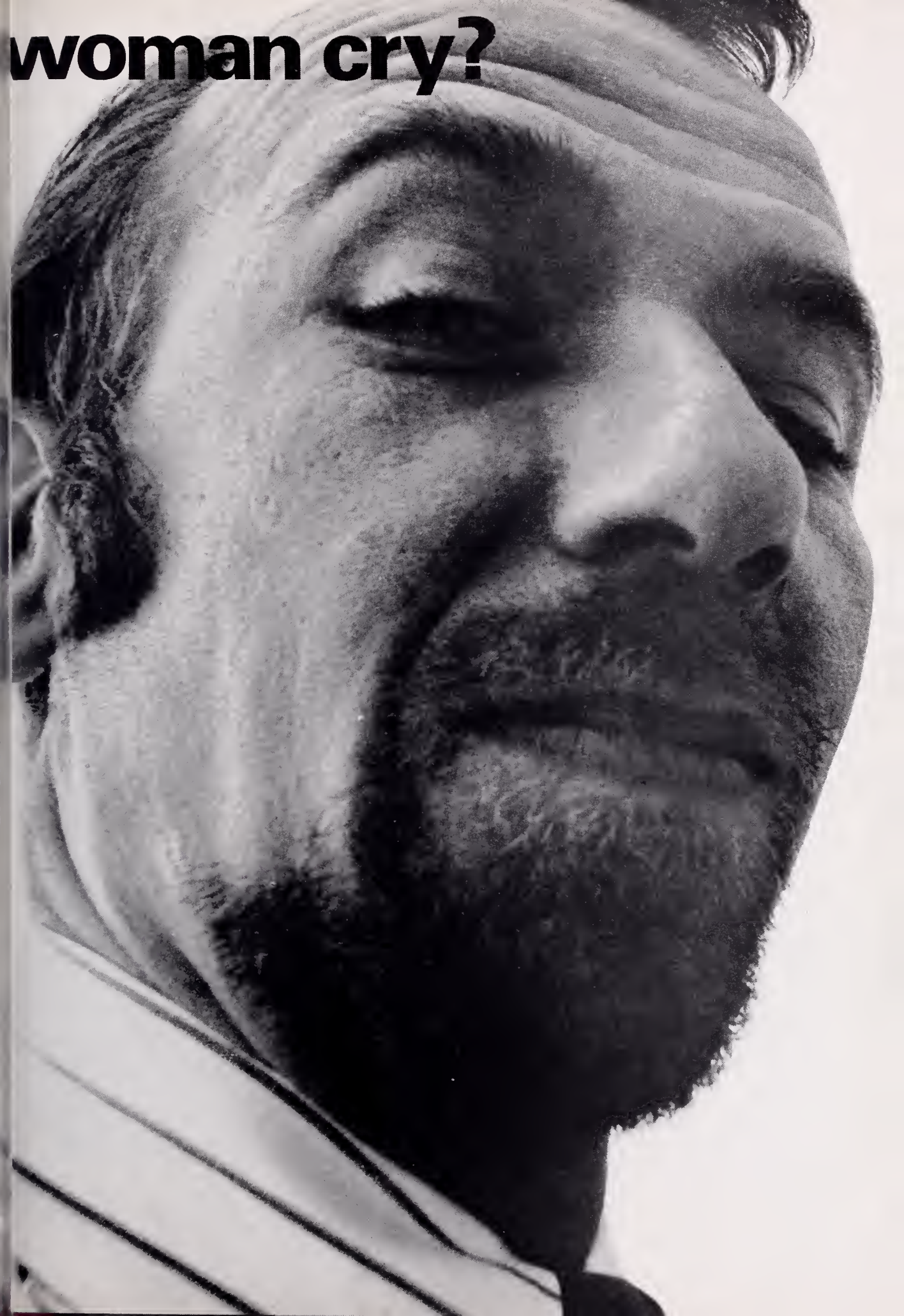

Eosinophilic Angiitis

Thomas O. Dotson, M. D., Enid Gilbert, M. D., and John B. Harley, M. D.

A wide spectrum of disorders have been described which are characterized pathologically by an angiitis varying in their degree of severity and clinically by a variety of symptoms including eosinophilia. We have recently had the opportunity to study a patient who presented with headaches, marked peripheral eosinophilia, Coomb's positive hemolytic anemia, and eosinophilic infiltrates in small vessels. The course of the disease was one of remissions and exacerbations and seemingly benign in nature. Histologic changes will be reveiwed and the place of this entity in the spectrum of disorders with vascular, immunological and hematological abnormalties will be discussed.

The Authors

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Case Report

F. B., a 23-year-old white male graduate student first entered the West Virginia University Hospital on February 5, 1966. His chief complaint was headaches which had been present since June, 1963. They were described as episodic, mostly dull, occasionally throbbing and relieved by rest and analgesics. The headaches had increased in severity in the three weeks preceding admission and had prompted him to seek medical attention.

When, because of headaches, he was seen initially at the University Health Service in February, 1964, a white blood cell count was 16,900/cu.mm. with 51 per cent eosinophils. Two weeks later he returned with hives, and a white blood cell count was 16,550/cu.mm. with 34 per cent eosinophils. No cause was found for the hives which were treated with antihistamines with no recurrence. There was no past history of allergic phenomena. He was seen next at University Health Service in January, 1966, again complaining of headaches. The white blood count at this time was 72,500/cu.mm. with 71 per cent eosinophils and he was referred to the University Hospital.

Past history revealed that he had not traveled outside of the United States but was in Fort Bragg, North Carolina, in June of 1963 for ROTC camp. There had been no periorbital edema, history of ingestion of raw pork, or any musular aches which could not be attributed to physical exertion. He had lost 10 pounds in weight over the past six months and complained of increased fatigue during the past few weeks. Mild watery diarrhea and a low grade fever occurred one week prior to admission. In general, he had been in robust health.

Physical examination revealed a well developed, well nourished, young, white male. Temperature 37.6°C., pulse 80/minute and regular, respirations 20/minute, blood pressure 120/80. Positive physical findings were a few small anterior cervical nodes and a 2 x 1 cm. node in the right axilla. The spleen and liver were not palpated. Proctoscopic examination disclosed normal appearing rectal mucosa. Neurological examination and the remainder of the physical examination were within normal limits.

Normal or negative studies included: urinalysis, VDRL, blood urea nitrogen, blood glucose, BSP, SGOT, uric acid, cold agglutinin titer, heterophile titer, LE Prep, bleeding time, clotting time, prothrombin time and numerous platelet counts. The serum electrophoresis was normal with the exception of an elevated gamma globulin fraction (2.0 grams per cent). Immunoelectrophoresis revealed normal quantities of IgG, IgA, and IgM.

There was evidence of hemolysis with a serum bilirubin of 2.8 mg. per cent (0.1 mg. per cent direct reacting fraction), a positive direct Coomb's test, fecal urobilinogen of 335 E. U. per day, reticulocytosis (8.2 per cent), and a hemoglobin drop of 2.7 grams per cent.

X-rays of the chest, skull, and abdomen were normal as was the electrocardiogram. Examination of the stools for ova and parasites was negative on several occasions. Skin tests for tuberculosis, histoplasmosis and trichinosis were negative. Lumbar puncture revealed clear spinal fluid with no cells and 25 mg. per cent protein. The electroencephalogram was normal.

Bone marrow aspiration showed a hypercellular marrow with marked predominance of eosinophils. There was a partial maturation arrest of the eosinophils at the myelocytic-metamyelocytic level. A few blasts with large nucleoli also were seen. The M:E ratio was 2:1.

Axillary node, liver and rectal mucosal biopsies are described in Figures 1, 2 and 3.

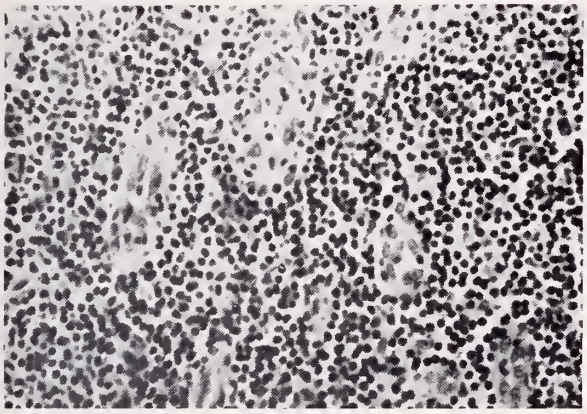

Figure 1

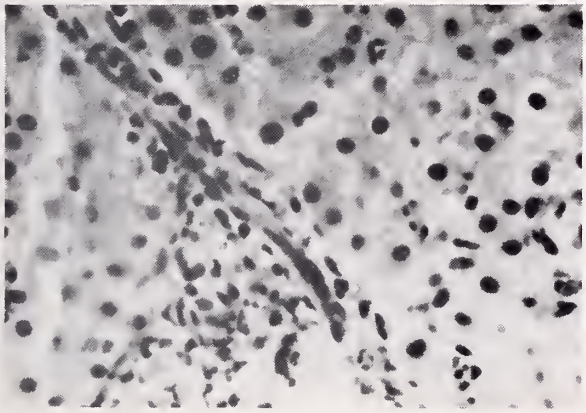

Figure 2

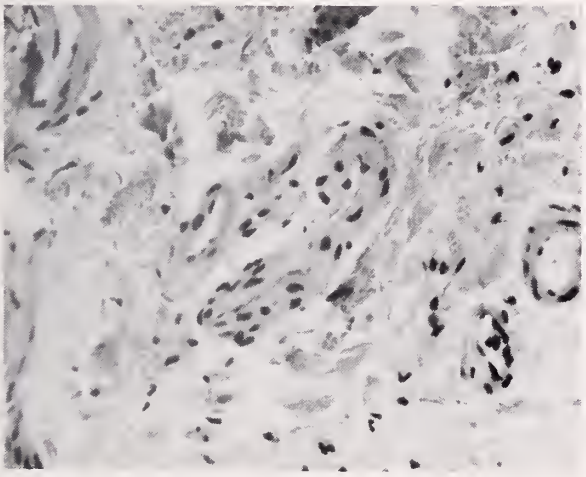

Figure 3

After a six-week course of every other day steroids (20, 15 and 10 mg.) the rapid resolution of hematologic abnormalities is depicted in graphic form in Table 1. The Coomb's test and serum bilirubin returned to normal and as the eosinophil count fell his headaches disappeared. He has remained without symptoms on no further therapy.

Pathological Findings

The axillary lymph node measured 1.5 x 1.0 x 0.5 cm., was ovoid, encapsulated and sharply circumscribed. Histological examination demonstrated a normal lymph node architecture with some degree of reactive hyperplasia as evidenced by lymphoid follicles containing prominent reactive germinal centers. The most striking feature, however, was the appearance of prominent capillaries which contained swollen endothelial cells, in some instances to the extent of apparent obliteration of the lumina. In addition, eosinophilic leukocytes infiiltrated the wall and were present in abundance in the perivascular spaces (Figure 1).

A needle biopsy of the liver revealed no alteration of the normal lobular pattern. Within the portal triads were infiltrates of inflammatory cells including lymphocytes, occasional polymophonuclear neutrophils and an abundance of eosinophiles. Here again these cells appeared to be principally located in and around vascular spaces. The vessels were also quite conspicuous by their strikingly swollen endothelial cells (Figure 2).

A biopsy of the rectal mucosa was obtained. The mucosal cells and stroma were normal. The marked eosinophile infiltrate as noted in the above biopsies was not observed. Several of the capillaries, venules and arterioles, however, showed proliferation of the endothelial cells, occasional eosinophiles infiltrating the wall and the wall of one venule in particular was quite edematous (Figure 3).

Discussion

The initial problem any clinician faces is the recognition and classification of his patient's disorder. In our case abnormalities were apparent in blood vessels (vasculitis), the hemopoietic system (marked leukocytosis and eosinophilia), and immunologically (Coomb's positive hemolytic anemia and hypergammaglobulinemia). We were unable to demonstrate parasitic infestation or pulmonary findings to merit classification as Loeffler's syndrome. There were no skin lesions or findings of lymphoproliferative disease. He gave no history of drug reactions, asthma or any allergic disorder.

Eosinophilic peritonitis, a disorder characterized by recurrent abdominal pain, diarrhea, vomiting and peripheral eosinophilia (60 per cent) has been described by one of us (J. B. H.[6]). Eosinophilic infiltrates of the peritoneum and small vessels, a course of remissions and exacerbations, and response to steroids are typical of this disorder. Harkavy[7] has described 16 patients with a syndrome of asthma, recurrent pulmonary infiltrates, polyserositis (peritonitis, pleuritis and pericarditis) and eosinophilia. Skin biopsies in three cases showed eosinophilic infiltrates in skin, nerves and vessels. Four patients died and postmortem examinations revealed typical lesions of periarteritis nodosa in three and necrotizing angiitis in one. Harkavy[8] was able to follow 11 of these patients from 4 to 10 years. They exhibited a relatively benign course. He concluded that this disorder was basically allergic in nature with blood vessels as the shock organ. Burhenne and Carbone[3] described a similar patient. Others[1, 12, 13,14] have described eosinophilic infiltrations of the gastro-intestinal tract. Three authors[2, 9, 17] have found eosinophilic granulomas of the stomach and small bowel in association with the intestinal parasite of the herring, Eustoma rotundatum.

McCombs[10] reviewed clinical syndromes associated with systemic "allergic" vasculitis. These included periarteritis nodosa, microscopic polyarteritis, allergic granulomatosis, Wegener's granulomatosis, serum sickness, hypersensitivity angiitis, drug hypersensitivity, vascular (anaphylactoid) purpura, "allergic" vasculitis, arteriolitis "allergica" cutis, and nodular vasculitis. He felt all cases of vasculitis did not fall into this classification and added infections, rheumatoid arthritis and lympho-proliferative disorders to this spectrum of vascular disease. He postulates that the basic pathogenic mechanism is similar and recognition of the presence of vasculitis and appropriate treatment with steriods is of more importance than a specific diagnosis. Seventeen of his 72 patients had nodular inflammation of smaller vessels (these fall into the variant of periateritis nodosa so ably described by Zeek.[19, 20, 21] Twenty-eight patients with drug induced or "idiopathic" vasculitis, however, had a benign course.

Segovia and Brown,[14] in their excellent review of necrotizing angiitides, conclude that there is a spectrum of vascular disease with granulomatosis (Loeffler's and eosinophilic granuloma) at one end and angiitis (periarteritis nodosa, allergic angiitis, and arteritis of collagen disease) at the other. An unusual syndrome was described by Churg and Strauss.[4] Of their 13 patients, 11 died within five years. Clinically, they exhibited severe asthma, fever, peripheral eosinophilia and diffuse vascular involvement of other organs. Tissue examination revealed necrosis, and granulomatous proliferation with epitheloid and giant cells. They suggest that this entity is different from periarteritis nodosa because of the extravascular changes. Winkelman and Ditto[18] described 38 patients with necrotizing angiitis of the skin, with mild arthralgia, microhematuria, eosinophilia and elevation of the erythrocyte sedimentation rate. Skin biopsies showed eosinophilic infiltrates plus vascular and perivascular fibronoid necrosis. Of four patients who died, two had lesions typical of periarteritis nodosa in large vessels and two in smaller vessels.

Table 1. Laboratory Examination

					Differential				
	Date	*Hgb. Grams/100ml.*	*Hct.*	*WBC/mm³*	*Eos.*	*Neut.*	*Lymph.*	*Retic.*	*Sed. Rate (mm/hr.)*
	2-6-64	15.3		16,900	51	26	18		
	2-25-64			16,550	34	40	24		
	1-29-66	11.6		72,500	71	14	13		
	2-1-66	14.2		87,500	90	10			96
	2-5-66	11.5	29	44,900	80	11	6		107
	2-8-66	11.5	33		77	14	8		
	2-9-66	11.3		31,000	81	7		8.2%	
	2-10-66	12.4	33	27,500	67	11	16	7.9%	
	2-11-66	12.8	37	25,800	70	14	15	6.6%	
Steroids	2-15-66	12.5	35	19,600	66	18	10		
Steroids	2-22-66	13.6	40	17,500	76	6	18		49
Steroids	3-1-66	13.3	40	15,200	60	18	21		
Steroids	3-8-66	15.0	44	8,400	35	31	35	0.7%	
Steroids	3-15-66	14.3	43	6,900	32	23	45		
Steroids	4-5-66	15.3	45	8,100	12	42	42	0.1%	
	8-9-66	16.0	44	7,600	7	45	47	0.2%	
	11-15-66	15.5	48	4,900	9	47	39		6
	6-20-67	17.2	48	5,700	7	43	50	0.1%	
	12-12-67	15.8	48	12,250	2	62	28		
	5-28-68	17.6		5,300	4	53	35		

Engfeldt and Zetterstrom,[5] in 1956, described disseminated eosinophilic collagen disease which is characterized by chronic or transient blood eosinophilia and involvement of many internal organs. Microscopically, there is focal interstitial tissue degeneration and necrosis (mainly eosinophiles) with vascular lesions varying in severity from slight endarteritis to necrotizing angiitis. In adults it is usually fatal within two years because of the cardiac changes. Odeburg[11] has reviewed the world literature regarding eosinophilic leukemia and casts doubt that true eosinophilic leukemia exists (i.e., apart from the terminal eosinophilia sometimes seen as the end stage of chronic myelogenous leukemia). He postulates that disseminated eosinophilic collagen disease and "eosinophilic leukemia" may be variants of the same (auto-immune?) syndrome. A closely related disorder was described by Zuelzer and Apt[22] in 1949. They reported a group of children with hyperglobulinemia, extreme eosinophilia and vascular lesions consisting of granulomata and focal necrosis.

In conclusion, our patient does not seem to "pigeon hole" into a previously described category. The absence of demonstrated granulomatous lesions, a mild eosinophilic vasculitis, hemolytic anemia and hypergammaglobulinemia would seem to place him near the angiitis end of the spectrum described by Segovia and Brown.[14] His benign course, peripheral eosinophilia, and clinical findings suggest an abortive form of disseminated eosinophilic collagen disease or "eosinophilic angiitis."

Summary

A case of marked peripheral leukocytosis with eosinophilia, Coomb's positive hemolytic anemia, infiltration of small vessels with eosinophiles and hypergammaglobulinemia is reported. The histological picture seems distinctive and of diagnostic significance. It is suggested that it be called eosinophilic angiitis and that it may represent an abortive form of eosinophilic collagen disease because of its benign nature.

A list of references may be obtained by writing to The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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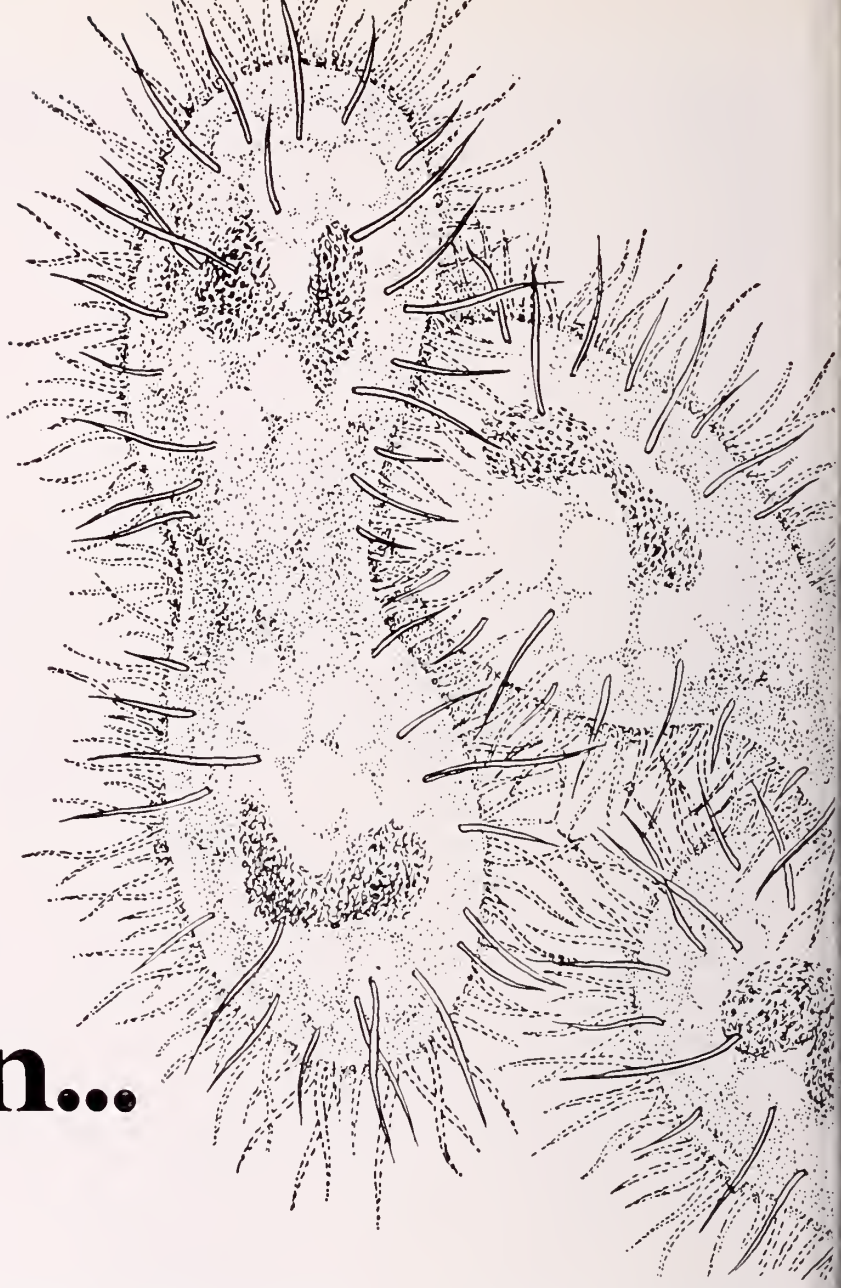

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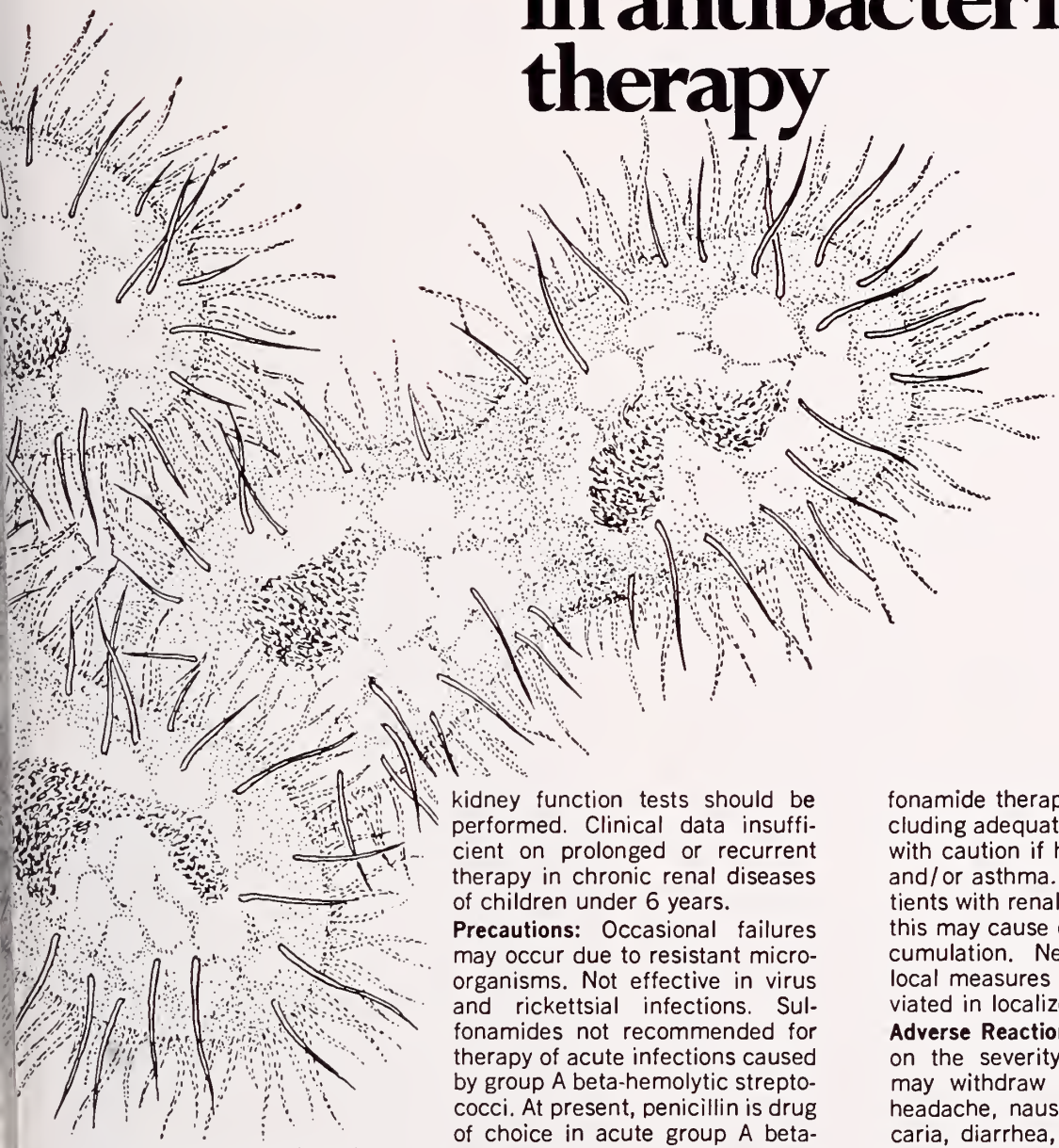

Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

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Lymphangiography in Malignant Genito-Urinary Tract Disease*

Arsenio M. Orteza, M. D.

The study of the lymphatic system since its discovery by Casper Aselli,[1] in 1623, had made slow progress and had gained little popularity in its clinical application until about a decade ago when Kinmonth[2] performed lymphangiography in man. This is probably explained by technical difficulty inherent in the study of small lymph vessels which ordinarily carry a colorless fluid and which may be only a potential space.[3] Monteiro[4] and associates, in 1930, performed adenolymphography by injecting Thorotrast into the lymph nodes of experimental animals. Menville and Ane,[5] in 1932, injected Thorium Dioxide into the tails and legs of rats and dogs and visualized the regional lymph nodes. Adenolymphography and indirect lymphangiography have met with limited success and have no practical clinical application in man.[6] Kinmonth and Taylor,[2] in 1954, first used direct lymphangiography in the study of idiopathic lymphedema of the lower extremities. Kinmonth, Taylor and Harper,[7] in 1955, described a technique of direct lymphangiography which until now has had only minor modifications.

Uses of Lymphangiography In Malignant Urologic Disease

1. *Diagnosis.*—The lymphangiogram has become a useful adjunct in the diagnosis of lesions involving the lymphatic system because of fairly characteristic changes in the lymph nodes that are visualized radiographically by this study. The retroperitoneal lymph nodes are accessible to examination only by the lymphangiogram. The typical appearance of normal lymph nodes and those involved by inflammatory disease, metastatic carcinoma, malignant lymphoma and irradiation therapy have been well described in previous publications.[8, 9, 10, 11] (Figures 1 and 2 show the normal pelvic lymph nodes and the thoracic duct emptying into the left subclavian vein, respectively). In combination with other diagnostic procedures such as the intravenous pyelogram, arteriogram, or phlebogram, the lymphangiogram demonstrates the lymphatics or lymph nodes in relation to an artery, an obstructed vein, or a displaced or blocked ureter.[12] As a diagnostic tool, the lymphangiogram is very helpful in cancer surgery where removal of the regional lymph nodes together with the primary lesion is of paramount importance.

2. *As an Aid in Judging the Extent of Surgery for Cancer.*—The lymphangiogram demonstrates the regional lymph nodes and depicts metastatic disease by unopacified filling defects in the lymph nodes. It also visualizes variations in lymphatic drainage, especially the contralateral lymphatic drainage at various levels in the body. Lastly, a postoperative lymphangiogram determines the completeness of lymphadenectomy.[13] The use of Ethiodol with Chlorophyll for preoperative lymphangiogram facilitates lymph node dissection.[14]

3. *As a Guide in Radiotherapy.*—Visualization of the abnormal lymph nodes by the lymphangiogram enables the radiologist to accurately localize x-ray therapy.

The Author

- **Arsenio M. Orteza, M. D., Department of Surgery, Division of Urology, West Virginia University Medical Center, Morgantown.**

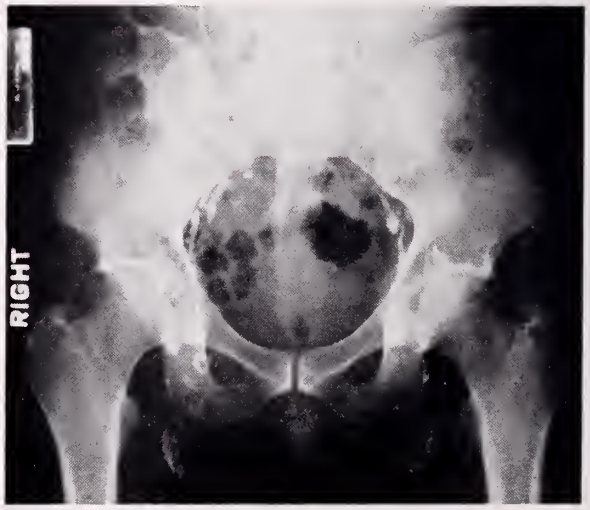

Figure 1. Normal pelvic lymph nodes.

***Presented before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 16, 1966.**

4. *Prognosis.*—Following lymphangiography, the lymph nodes remain opacified for at least four weeks. This enables one to assess the response to irradiation or chemotherapy by visualizing any change in the size of diseased lymph nodes.

5. *Radioactive Lymphangiography.*—Although radioactive lymphangiography is in the experimental stage at present, there may be indication for its clinical application as a therapeutic measure.[15]

Complications of Lymphangiography

Fever is one of the most common minor complaints following lymphangiography. A temperature rise which lasts from 24 to 72 hours is attributed to fine pulmonary embolization of the oily contrast medium. Massive pulmonary embolism is the most serious complication if excessive amounts of the contrast medium are injected very rapidly.[16] Pain at the site of injection[17] is rare, even with extravasation of the contrast medium, if adequate amounts of local anesthetic are used. Wound infection and bacterial lymphangitis are avoidable with aseptic technique.

Chemical lymphangitis with Ethiodol is rare. A history of iodine sensitivity should be determined before initiating the study. Lipogranulomatous reaction in the lymph nodes has been observed but its significance is not fully known.[18] Tumor embolism is a theoretical possibility but unlikely. Zeidman[19] and associates demonstrated that carcinomatous tumors obliterate lymph spaces and lack lymphatic supply.

Figure 2. Normal thoracic duct emptying into left subclavian vein.

Our Modified Technique of Lymphangiography

The technique as originally described by Kinmonth, Taylor and Harper,[20] in 1955, is generally employed with only minor modifications. A blue dye is injected into the web between the first and second toes and an incision is made about two inches proximally on the dorsum of the foot. A lymph vessel is identified and cannulated with the largest possible needle one can use, usually about a #27 gauge needle. The radiopaque medium is then injected either manually[18] or by a mechanical pump.

The technical difficulty of cannulating a lymph vessel and keeping the needle in place during the lymphatic injection makes the procedure quite tedious and time-consuming. One, therefore, has used a modified procedure in a series of 40 cases studied from August 1, 1963 to January 1, 1965.

The procedure is performed with the patient lying comfortably in his own bed (Figure 3). The legs are thoroughly cleansed, sterilized with an antiseptic solution, and draped with sterile towels. One-half cc. of a 50-50 mixture of Evans Blue Dye and one per cent Lidocaine is injected intradermally into the anteromedial aspect of the distal third of the legs over the course of the greater saphenous vein. Fifteen minutes after the injection of the blue dye, an incision is made directly over the greater saphenous vein two inches proximal to the site of the dye. A lymphatic vessel is identified and cannulated with a #27 gauge needle. The contrast medium (Ethiodol) is injected with the use of a mechanical pump and the operative field is examined for extravasation of the contrast medium. If there is no leak, the skin incision is closed with interrupted silk sutures.

Figure 3. A modified technique: lymphatic cannulation at leg level.

Immediately after the lymphatic injection is finished, the needles are removed, pressure dressings are applied, and the patient is sent for x-ray pictures of the pelvis, abdomen and chest. These pictures are repeated 24 hours later.

Case Reports

Case 1.—(Hospital No. 13-08-12). A 28-year-old white male who had a left orchidectomy and left groin dissection performed elsewhere eight months previously for embryonal cell carcinoma of the left testis was admitted February 27, 1964, with a palpable mass in the left flank. The intravenous pyelogram showed normal right kidney and a nonfunctioning left kidney. The lymphangiogram demonstrated a large, unopacified lymph node in the left retroperitoneal area at L3 level producing lymphatic obstruction (Figure 4). This metastatic lesion responded dramatically to x-ray therapy and completely resolved, as proven by subsequent surgical exploration.

Case 2.—(Hospital No. 12-96-92). A 54-year-old male had a transitional cell carcinoma involving almost the entire right half of the base of the bladder. The lymphangiogram showed normal pelvic lymph nodes. The patient underwent total cystectomy and ileal bladder and has been free of residual or recurrent tumor. One year postoperatively the IVP showed normal kidneys with functioning ileal bladder. (Figure 5).

Case 3.—(Hospital No. 12-75-12). An 80-year-old male was admitted October 16, 1963, with anorexia, generalized weakness and loss of weight, and was found by biopsy to have adenocarcinoma of the prostate gland. The lymphangiogram showed involvement of a pelvic lymph node (Figure 6). Bilateral orchidectomy and Estrogen therapy gave good palliative results.

Case 4.—(Hospital No. 12-75-53). A 57-year-old female was found to have a pelvic mass. Urologic studies showed right ureteral obstruction seven centimeters above the orifice with nonfunctioning right kidney. The lymphangiogram showed a pelvic lymph node involved by metastatic tumor (Figure 7). Cervical biopsy revealed squamous cell carcinoma. The patient was treated with chemotherapy. The lymphangiogram demonstrated the cause of ureteral obstruction.

Case 5.—(Hospital No. 12-80-91). A 51-year-old female was admitted to the Gynecology Service because of carcinoma of the cervix, with a palpable mass in the pelvis and edema of the left lower extremity. The IVP showed nonfunctioning left kidney. The lymphangiogram performed in the left lower extremity demon-

Figure 4. Lymphangiogram showing complete obstruction of lymphatics at L3 level on left.

Figure 5. Postoperative IVP showing normal kidneys and functioning ileal bladder.

strated complete lymphatic obstruction in the pelvis and crossing of the lymph vessels at the level of the pelvic floor to drain into the contralateral iliac lymph node (Figure 8).

Discussion

Lymphangiography is of value in visualizing the pelvic and retroperitoneal lymphatics which otherwise could not be demonstrated by ordinary methods of examination. It demonstrates lymph nodes involved by tumor. It gives one an idea of the extent of tumor spread and helps determine the operability of a given case. In inoperable cases, it affords clinical assessment of response to therapy with irradiation or chemotherapy by showing any regression in the size of diseased lymph nodes.

It demonstrates the crossing of lymphatics at various levels and the necessity for bilateral node dissection in many cases. The lymph vessels may cross at L3-L4 levels (Figure 9) or as low as S1-S2. These have been observed in previous studies.[21, 22] In our present series of 40 cases, however, crossing of the lymphatics in the pelvic floor and visualization of the contralateral iliac lymph node has been observed (Figure 8).

Except for the study of lymphedema of the extremities, the lymphangiogram is done mostly to study the inguinal, pelvic and retroperitoneal

Figure 6. Lymphangiogram showing unopacified enlarged lymph node along iliac chain.

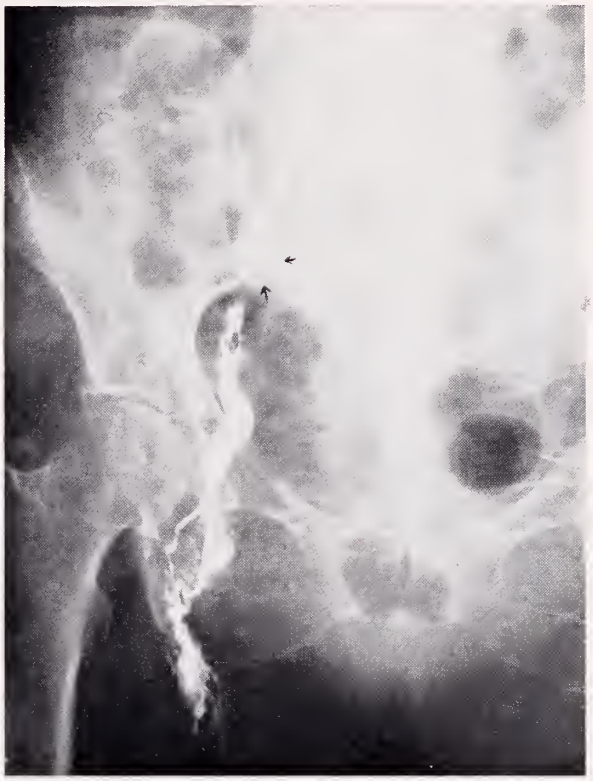

Figure 7. Lymphangiogram showing unopacified lymph node at site of ureteral obstruction.

Figure 8. Lymphangiogram demonstrating crossing of lymphatics in pelvic floor, draining into contralateral iliac lymph nodes.

lymph nodes. For this purpose, it is not necessary to inject the blue dye into the interdigital web and make the incision on the dorsum of the foot as it is generally practiced. A leg incision has distinct advantages over the conventional incision on the dorsum of the foot. First of all, the needle in the leg can be more securely placed and its chances of being dislodged are much less than when it is inserted into a lymph vessel and taped on an uneven surface, near a movable joint such as the dorsum of the foot. Secondly, the leg incision is not interfered with when the patient ambulates and it heals much better than that on the dorsum of the foot. Lastly, at the leg level, the lymph vessel is technically easier to cannulate.

Figure 9. Lymphatic crossing at L3-L4 level.

Use of a splint to immobilize the extremities[23] is unnecessary. The patient may be allowed some foot and leg movements with the needle located as described. With a properly anchored and securely taped needle, the contrast medium flows faster when some leg movement is allowed. An indwelling urethral catheter is not necessary if the patient voids before the procedure is started. A scout film 15 minutes after beginning the lymphatic injection[24] to determine whether the contrast medium is flowing freely in the lymph vessel probably is unnecessary because dye extravasation becomes readily apparent a few minutes after the injection has begun. If there is no extravasation after five minutes, one can be reasonably sure the needle is in good position.

Summary

The clinical applications and some of the usual complications of lymphangiography are reviewed. A modified technique for evaluation of the pelvic and retroperitoneal lymphatics in malignant urologic disease is described. Representative cases of neoplasms involving the genitourinary tract are reported.

A list of references may be obtained by writing to The Journal.

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Electrocardiogram of the Month

Rate-Dependent Left Bundle Branch Block

Edward K. Chung, M. D.

Lewis, in 1913, was the first to report a case of unstable bundle branch block.[1] Rate-dependent bundle branch block was not reported until 1931 by Herrmann and Ashman.[2] In 1941, Vesell described, for the first time, the importance of critical cardiac rate for the production of bundle branch block.[3]

The Author

- **Edward K. Chung, M. D., Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratory, West Virginia University School of Medicine, Morgantown.**

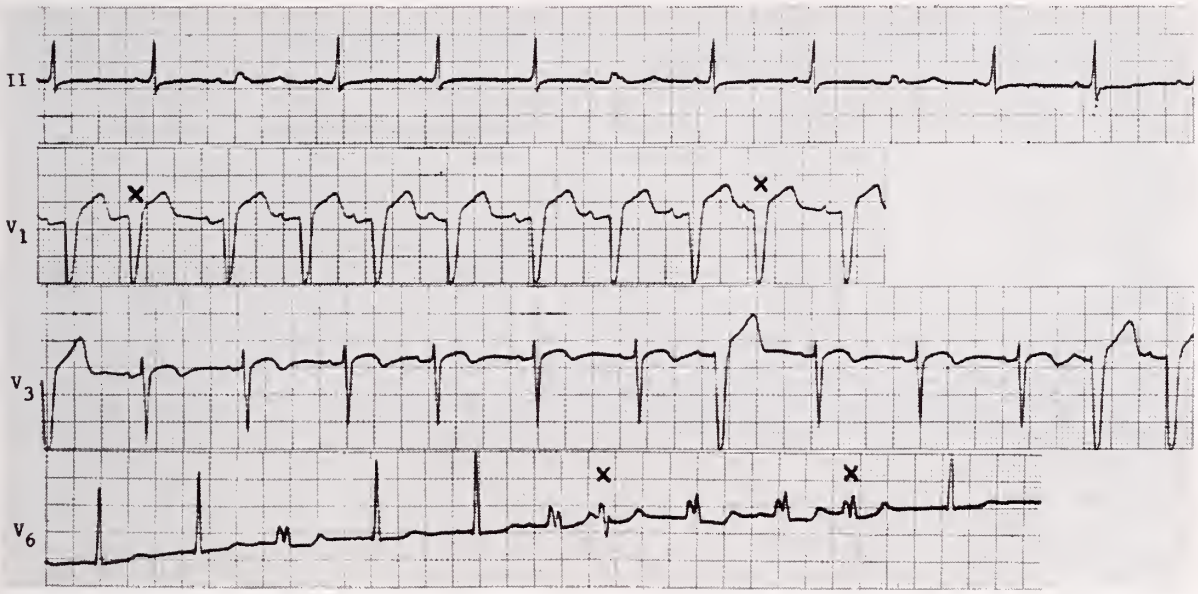

Figure 1. The tracing shows sinus arrhythmia with rate varying between 80 and 110 per minute. Note wide QRS complexes during faster rates because of rate dependent left bundle branch block. There are A-V nodal premature contractions which show wide QRS complexes (marked X).

The purpose of this paper is to report a case of rate-dependent left bundle branch block and to review the literature concerning the subject.

Case History—A 77-year-old white female was admitted to the hospital after being hit by a truck resulting in the fracture of four ribs, the right tibia and fibula, and bilateral fracture of the superior and inferior pubic rami. The patient gave a history of hypertension for several years and a history of myocardial infarction two years prior to admission. The blood pressure on admission was 210/110. Examination also revealed the heart to be enlarged to percussion. The electrocardiogram showed a sinus arrhythmia with intermittent rate-dependent left bundle branch block and occasional A-V nodal premature contractions (Figure 1). Following treatment of the fractures, the hospital course was uncomplicated.

Discussion—Intermittent bundle branch block is not an uncommon electrocardiographic finding and occurs predominantly in older patients and/or patients with organic heart diseases, though a few cases have been reported in subjects with no demonstrable heart disease.[4] The heart disease in most of the cases with intermittent bundle branch block is ischemic and/or hypertensive.[5] The conducting system including bundle branches in patients with underlying heart disease are readily influenced by various

factors including slight changes in the cardiac rate.[4] In most of the cases with intermittent bundle branch block, slowing of the cardiac rate results in normal ventricular conduction, while an increment of the rate results in the appearance of bundle branch block. However, a reverse phenomenon has been reported.[6]

Some reports indicate that slight alterations in rate can be vital in producing a rate-dependent bundle branch block and a rate change of a beat or two per minute can produce a bundle branch block.[3,7,8]

The mechanism of intermittent bundle branch block is still speculative. Carter and Dieuaide, in 1923, thought that there might be a few intact fibers of the bundle remaining, which with favorable conditions could result in normal conduction. A slight decrease in the circulation, however, might produce failure of these fibers causing the conduction defect.[9] It is also thought that above the critical rate, the impulses might reach the damaged bundle during the refractory period and thus not be conducted. Baschmakoff, in 1930, demonstrated in animal experiments, that if one bundle was cut so that a few fibers remained, conduction was normal at slow heart rates, but a bundle branch block arose with faster rates.[10]

Clinically, an intermittent left bundle branch block is very useful in diagnosing myocardial infarction during normal intraventricular conduction because myocardial infarction is very difficult or almost impossible to diagnose in the presence of left bundle branch block electrocardiographically.

The prognosis in intermittent left bundle branch block depends primarily on the underlying cause. Most common underlying causes of rate-dependent left bundle branch block are hypertensive and/or ischemic heart disease. In general, intermittent bundle branch block eventually becomes permanent when the patients become older and the heart disease progresses further.[3,11]

Summary—A case of rate-dependent left bundle branch block is presented. This condition occurs most frequently in the presence of ischemic and/or hypertensive heart disease. The probable mechanism and importance of rate-dependent left bundle branch block are discussed briefly. Most of the cases with rate-dependent left bundle branch block progress to permanent left bundle branch block with advanced age and progression of heart disease.

Acknowledgment

The assistance of Richard G. Stevenson, B. A., senior medical student, is gratefully acknowledged.

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A message from . . .

The President

GREATER INVOLVEMENT NEEDED

I have just finished reading over the President's Page in the April issue of *The Journal.* I mentioned that there may be some other issues I might like to write about, but for the present time I feel this is sufficient except for one thing. It was brought out by many speakers at the Socio-Economic Congress in Chicago that all doctors should be interested in what is going on and it is of course the experience in every hospital staff, medical society and so forth that generally there is a hard nucleus of doctors who are interested in this matter.

I feel in some component societies of our State Medical Association that many of our colleagues do not have access to the facts and that we should endeavor to enlist them in all these activities, as much as possible. I know every physician is busy and to some these activities are boring. The idea of letting "George do it" is prevalent. However, if we are to succeed we must be united as much as possible and to encourage those physicians who have not served on any committees of the medical staff or society to do so. I know there is a great tendency on the part of many staffs and societies to reappoint people that have been doing the work for a long time. I mentioned recently in a talk before the McDowell and later the Mercer County Medical societies that it has been suggested to include the younger physicians even on the grievance committees. This, in the past, has been more or less left up to the older doctors. The younger ones should be brought into these committees so that they will have some understanding of what is going on.

It appears to me that we have another fight coming up. This is in regard to the proposal by the Federal Government to regulate the fee schedule for Medicaid. It is the opinion of some people that this is another step toward complete socialization. It is necessary for us to fight this with all our vigor. On the other hand, as I said before, it is very necessary that we participate in all conferences relating to health cost and, although there is an inflationary spiral going on, try to keep these costs within reasonable limits.

Recently, I attended the meeting of our Scholarship Committee at the West Virginia University School of Medicine. It certainly can be said that you would be proud of the young men and women who applied for these scholarships. Unfortunately, we were able to provide only two and I feel that the right decision was made as to the two recipients; however, many others were very seriously considered and the Committee was not unanimous in its decision. I know I was proud of the young men and women who were applying for these scholarships from our State. As you may know, the House of Delegates is to receive a report from the Special Committee on Loans and Scholarships which it authorized at its meeting in 1968 at The Greenbrier. Although I have my own personal feelings about this I will not voice them as I feel that this is up to the House of Delegates and the facts be presented to them: Loans vs. Scholarships. All I can say is that certainly both groups are sincere regarding this problem.

Richard W. Corbitt MD.

RICHARD W. CORBITT, M. D., *President*

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EDITORIALS

LETTER TO THE EDITOR

On March 15, 1968, Dr. Richard V. Lynch, Jr., then President of the West Virginia State Medical Association, spoke to the Student American Medical Association Chapter at West Virginia University. During this visit the medical students expressed a desire to know more about the practice of medicine in the State. They related that few of the students came from physician families and that a majority of the students knew only a few physicians in their home towns. The idea of a joint project between SAMA, State Medical Association and the county medical societies was fostered to resolve these desires.

During the summer, Ralph Greene, Chapter President, and I had correspondence with Doctor Lynch and Mr. William H. Lively on initiating a series of programs featuring private practitioners in West Virginia.

In August, I was privileged to represent the National Executive Council and West Virginia University Chapter of the Student American Medical Association at the 101st Annual Meeting of the West Virginia State Medical Association.

During my stay at The Greenbrier, I was continually asked "What do the students want from us (practicing physicians)?" and "How can we interest the medical students in staying in West Virginia?" I related what had transpired on Doctor Lynch's visit and the plans to start a series of programs to establish a better relationship between the students and the physicians.

I suggested that the respective county societies contact the students from their areas and arrange opportunities for both parties to meet. This could be done during vacation breaks or in the summer. I also pointed out that University Hospital has a house staff of approximately 125 interns and residents. Many of these physicians might be interested in remaining in West Virginia if they knew more about needs and opportunities in various areas.

It must be recognized that the medical students are well aware of the physician shortage in this country. They know that they can practice about anywhere and make a much needed contribution to the health care system. The environment, or better, the community becomes a major factor in deciding where to practice. The physicians of tomorrow are not interested in communities that are stagnant, that lack civic pride and desire to improve. Medical communities, as well as civic leaders that show an interest in a student, are remembered.

When I returned to Morgantown, I was encouraged by interest shown by dozens of physicians. I related my experiences to the chapter officers and students. Ralph Greene wrote to

each county society emphasizing again the desire to improve relationships, to provide students to speak, and to request their cooperation in establishing the programs mentioned.

To date only four county societies have responded in any form. Harrison County, under the direction of Dr. Robert D. Hess, has continued its policy of inviting the medical students from that county to attend their meetings. Monongalia County recently had several SAMA officers to one of their meetings. Marshall County and Central West Virginia societies wrote for lists of students from their areas.

To put it mildly, the response was very disappointing to the chapter officers and myself. The program initiated in December between the SAMA Chapter and the State Medical Association would not have been possible without the excellent cooperation of Dr. Richard W. Corbitt and the Executive Council.

It was known already that the members of the Council recognized the need and importance of better communications between the medical students and the private physicians. The poor response from county societies raised question of "Are they really interested and concerned?"

For me this is a difficult question to answer. In August, I would have said "Yes," but in May I must say, "I'm not sure." There are 17 residents who will complete their training in June. These physicians have spent from two to five years at West Virginia University Hospital. How many of these men have been approached about practicing in West Virginia or to return after completing their military obligations? I know of examples where the faculty have encouraged men to open practice in the State. The usual reply is, "Why haven't I been contacted by any of the private practitioners?" Many out-of-state communities actively recruit the WVU house staff. The clinical students are well acquainted with these situations and also wonder why.

West Virginia has many problems to solve in order to grow. The medical students have been guilty, as have been a majority of the other college graduates, in adopting a defeatist attitude about the State. This has resulted in a mass exodus of young leadership material to other states.

I sincerely feel if the students can be shown that the medical community is concerned with solving health care problems in West Virginia, that it is concerned with correcting the numerous socio-economic problems, then the results will be surprising. The energy and enthusiasm of youth may enter into the mainstream of life in West Virginia and help our State grow.

R. Brooks Gainer, II
Senior Medical Student
Region 3 Vice President of
Student American Medical Assoc.

ANSWER FROM THE EDITOR

A letter to the Editor from R. Brooks Gainer II, senior medical student at West Virginia University and Region 3 Vice President of the Student American Medical Association, details some information pertinent to the West Virginia doctor shortage. This information is of vital importance to the West Virginia State Medical Association and its county affiliates as well as to those West Virginians who live in areas where there is a scarcity of physicians. Mr. Gainer believes that organized medicine is not exerting its maximal influence to keep our graduates, interns and residents in West Virginia. The facts agree with Mr. Gainer's statement.

Maybe we are tired of talking and tired of listening to this matter of doctor shortage, but this is no reason to quit the struggle, nor can we expect the problem to resolve itself. It will take continuous prodding, intensification of effort, and development of new maneuvers to meet this critical situation.

Those of us who have communicated with the senior students believe they have a genuine desire to remain in West Virginia or return to West Virginia after graduate studies and military responsibilities are fulfilled. This natural desire must be fostered and strengthened through the student years. The recent medical graduate can go anywhere and can do whatever he wishes. If he has a graduate residency outside of West Virginia he will be subjected to unceasing pressure to remain and practice in his new residence. We also have to compete with increasing allurement from third party medicine; such as armed forces, Veterans Administration, public health, industrial medicine, etc.

The lack of response to the student's plea for interest can only mean that medical societies are uninterested or that the members are too busy to concern themselves with the local doctor shortage, but they must become aroused if their community needs are to be met. It is unlikely that the medical student will return to his native heath without a lot of urging and inducement.

We have various classifications of membership in our county societies. Why not a special classification for medical students of West Virginia University or any U. S. or foreign school that the local resident may be attending? Such student members should receive local bulletins and should have personal interviews which indicate the advantages of family or specialty practice in the area. We are unaware of any area that is overstocked with physicians, or of any society that would not welcome the return of a native son.

A project to interest the residents and interns in all West Virginia hospitals with approved teaching programs should be undertaken by some arm of the State Medical Association. This project might be in charge of those physicians who have received their graduate training in West Virginia and remained to practice within the State. There was an excellent report on this problem in the April 1968 issue of *The Journal* by Dr. Jack Pushkin of Charleston, who at that time was President of the West Virginia University House Staff Association. A simple questionnaire to all residents and interns in West Virginia might serve to discover those students who are still open minded about their medical future. Most of our students and residents are married so that the decision of where to practice becomes a family affair. Herein lies an opportunity for the Auxiliary to play a useful part.

The recent Medical Practice Act lowers the requirements for foreign graduates to receive full West Virginia licensure. The next year should indicate if such leniency attracts foreign graduates in sufficient numbers to substantially relieve the doctor shortage. Before this might occur, should we not make some special efforts in the direction of our own boys?

Correspondence on this critical subject is invited.

SOLID TUMOR CHEMOTHERAPY

The first in a series of three essays on "Solid Tumor Chemotherapy" appears in this issue of *The Journal*. The three manuscripts will be published consecutively in the June, July and August issues. The papers complete an exhaustive and authoratative study of all medications in current use to halt the growth of inoperable malignancy. This information will be a ready reference for many of us who attempt the medical treatment or palliation of any manner of inoperable cancer.

All the little niceties in the presentation of therapy to the adequately prepared patient are given in detail in the first section of this manuscript. The author stresses the fact that this treatment cannot materially prolong life and in turn it is the responsibility of the physician to emphasize this fact to his patient.

For those who wish to pursue their particular interest, the author presents a long and detailed reference list.

The drug list is extensive and detailed. The manner of appearance of toxic signs is emphasized and the tables should be most helpful to physicians dealing with these drugs.

The Journal is glad to have the opportunity to present this three-part symposium and we are grateful to Doctor Watne for giving us this publication preference. Even if you don't save your Journals, you should clip these three manuscripts for your library.

TIME IS SHORT

June 30 is the deadline for congressional action to outlaw the FCC ban on television and radio advertising of cigarettes. If you believe cigarette smoking plays a part in the increasing morbidity and mortality of heart and lung diseases, you can do your part to make the ban effective by thwarting selfish congressional interference.

Your senators and representatives always wish to have the voice of their people. So here is your chance to strike a personal blow for cancer control. Please do it now by letter or telephone.

TIME IS SHORT!

The Key

He's an old cabbie. He's been listening to back seat conversations for years. He's something of a philosopher if you let him air his views.

How does he know you're a Doc? Why does he tell you things you can't believe he would confide to an ordinary fare? How did you give yourself away to his discerning ear?

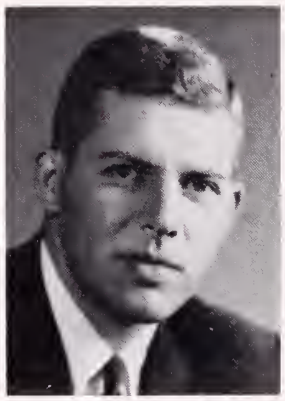
People somehow sense the medical man and they "give." One driver says we dress differently. Another says we "talk educated." The M. D. must expect to listen to commonplace and uninteresting personal histories in return for being let into this man's house. But he may pick up little gems of human interest which would be a livelihood for such talented folk as Damon Runyon.

The key to these people's confidences must be won through study, the sharing of experiences and a common appreciation of man's problems. Therefore, Doc should recognize his privileges and wear his key to mankind with humanity, humility and pride.—*Massachusetts Physician.*

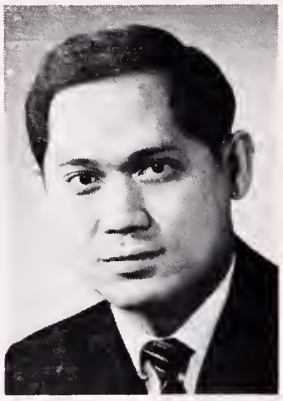
GENERAL NEWS

Drs. Young and de la Cruz To Speak At 102nd Annual Meeting

The Program Committee has announced the names of two additional prominent physicians who have accepted invitations to appear as guest speakers at the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.



W. Glenn Young, Jr., M. D.



Felix F. de la Cruz, M. D.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Dr. W. Glenn Young, Jr., of Durham, N. C., and Dr. Felix F. de la Cruz of Bethesda, Maryland, will present papers during the three-day meeting.

W. Glenn Young, Jr., M. D.

Dr. W. Glenn Young, Jr., Professor of Surgery at the Duke University School of Medicine, will appear as a speaker at the third general scientific session on Saturday morning, August 23. The session will be devoted to a Symposium on "Cardio-Respiratory Emergencies and Their Management." Also participating in the program will be an internist and an anesthesiologist.

A native of Washington, D. C., Doctor Young was graduated from Duke University and received his M. D. degree in 1947 from the Duke University School of Medicine. He interned and served as a research fellow and resident in surgery at Duke University Hospital. He served with the Medical Corps of the United States Navy, 1950-52.

He joined the faculty of the Duke University School of Medicine in 1955 and has been serving as Professor of Surgery since 1963.

Doctor Young is a Diplomate of the American Board of Surgery and Thoracic Surgery and is a member of Phi Beta Kappa. He is a member of the Society of University Surgeons, American Surgical Association, Society of Thoracic Surgeons and the American Federation for Clinical Research.

Felix F. de la Cruz, M. D.

Dr. Felix F. de la Cruz, Chief of the Children's Diagnostic and Study Branch, National Institute of Child Health and Human Development at the National Institutes of Health in Bethesda, Maryland, will appear as a speaker at the second general scientific session on Friday morning, August 22.

A native of the Philippines, Doctor de la Cruz received his M. D. degree from the University of Santo Tomas in Manila. He received a Master of Public Health degree in 1961 from Johns Hopkins University School of Medicine.

He interned at the 6208th United States Air Force Hospital and served a residency at the University of Washington School of Medicine in Seattle. He served as a staff pediatrician at the Rainer School in Buckley, Washington, 1958-64, and was affiliated with Johns Hopkins University School of Medicine while on educational leave of absence from the Rainier School. He has been affiliated with the National Institutes of Health since 1964.

He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics and the American Association on Mental Deficiency.

Scientific Program Nearly Completed

Doctor Stark announced that plans for the three general scientific sessions have been completed and the officers of the sections and affiliated societies are in the process of lining up speakers for the afternoon meetings.

In addition to Doctors Young and de la Cruz, the following physicians and surgeons also will appear as guest speakers at the meeting:

Dr. Emanuel M. Papper, Professor and Chairman of the Department of Anesthesiology, College of Physicians and Surgeons of Columbia University, New York City.

Maj. Gen, Joe M. Blumberg (MC), Commanding Officer of the United States Army Medical Research and Development Command, Washington, D. C.

Dr. Kermit E. Krantz, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center.

Dr. Raymond J. Jackman, Head of the Section of Proctology at the Mayo Clinic, Rochester, Minnesota.

Dr. Albert B. Ferguson, Jr., Professor and Chairman of the Department of Orthopedic Surgery at the University of Pittsburgh School of Medicine.

Dr. Bruce C. Sinclair-Smith, Associate Professor of Medicine, Vanderbilt University, Nashville, Tennessee.

Honor Guests to Attend Meeting

Two honor guests have accepted invitations to deliver addresses during the three-day meeting.

The Hon. Arch A. Moore, Jr., Governor of the State of West Virginia, will deliver an address at the opening of the first general scientific session on Thursday morning, August 21.

Dr. Gerald D. Dorman of New York City, who will be installed as President of the American Medical Association during the Annual Convention in July, will speak at the first session of the House of Delegates on Wednesday afternoon, August 20.

Members of the Auxiliary and other guests attending the meeting at The Greenbrier are cordially invited to listen to the addresses by Governor Moore and Doctor Dorman.

Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 23.

Drug Use Among Students

Five per cent of American college students have tried LSD and 20 per cent of high school and college-age youth have experimented with marijuana and other hallucinogenic drugs, an expert estimates.

Dr. Henry Brill of Brentwood, New York, Chairman of the AMA Committee on Alcoholism and Drug Dependence, made the estimates recently in testimony before the Health Subcommittee of the U. S. Senate.

He said physicians are being called upon more and more to treat patients with drug problems.

Heavy Room Reservations At The Greenbrier

Reservations for the 102nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23, have passed the 450 mark as this issue of *The Journal* goes to press.

The management has assured Association officials that every effort will be made to arrange accommodations for all those interested in attending the convention. It is important, however, that reservations be made as soon as possible so that some idea may be had by the management concerning the total number of rooms that will tbe needed to house those attending the meeting in August.

Requests for rooms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, W. Va. 24986.

Death Claims President Of AMA Auxiliary

Mrs. Clifton C. Long, President of the Woman's Auxiliary to the American Medical Association, died of cancer on April 22 in a hospital in her home town of Ozark, Arkansas. She was 49.

Mrs. John M. Chenault of Decatur, Alabama, President Elect of the Auxiliary, immediately assumed the presidency. She will be installed officially at the Auxiliary convention in New York City in July.

Mrs. C. C. Long

Mrs. Long had been in failing health for several months. She had made a trip to France as a representative of the Auxiliary and was hospitalized immediately upon her return to this country.

Mrs. Long had worked on various Auxiliary projects up to the time of her death. She had planned to testify before a congressional committee in hearings on television and motion picture violence.

A native of Topeka, Kansas, Mrs. Long leaves her husband, Dr. Clifton C. Long, a surgeon; and four children.

Medical Careers Club Active In Ohio County

More than 200 high school students are members of Future Medical Careers Clubs in Ohio County.

Mrs. Alice Trapp, wife of Dr. Donald C. Trapp of Wheeling, is Chairman of the organization, which has chapters at Triadelphia, Wheeling, Warwood and Wheeling Central High Schools. Each high school unit has a member of the faculty and a member of the Woman's Auxiliary to the Ohio County Medical Society as sponsors.

Meetings are held once a month with guest speakers. One recent speaker was Dr. Robert Weiler, an orthopedic surgeon, who presented a talk on the dangers of motorcycling.

Eighty members and four sponsors toured the West Virginia University Medical Center in Morgantown on April 28.

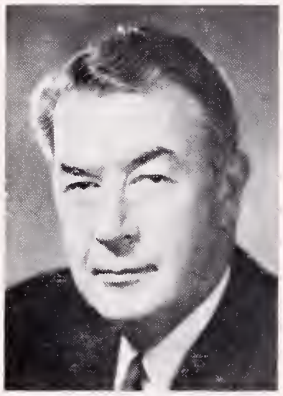
Mrs. Trapp said most of the members are girls, but an effort will be made to attract more boys to the clubs.

Doctor Flood Named IMA Fellow

Dr. Richard E. Flood of Weirton, a Past President of the West Virginia State Medical Association, was admitted to fellowship in the Industrial Medical Association during a ceremony held in Houston, Texas, in April.

Annual AMA Convention In New York City

The 118th Annual Convention of the American Medical Association will be held in New York City, July 13-17. Attendance is expected to exceed 60,000 persons, including 22,500 physicians.



C. A. Hoffman, M. D.

Frank J. Holroyd, M. D.

Much of the scientific program will be conducted in the Coliseum and the New York Hilton Hotel, while the policy-making House of Delegates will have its sessions at the Americana Hotel.

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington will represent the West Virginia State Medical Association in the House of Delegates. The Alternate Delegates are Drs. Thomas G. Reed of Charleston and Richard E. Flood of Weirton.

Dr. Hoffman To Be Nominated

The name of Doctor Hoffman will be placed in nomination on Thursday, July 17, for the office of Vice Speaker of the House of Delegates.

Doctor Hoffman, a member of the House for several years, is a Past President of the West Virginia State Medical Association. He has held many other important positions in both the State Medical Association and the American Medical Association.

Several other prominent physicians from other parts of the nation also are seeking the office of Vice Speaker.

General Scientific Sessions

Four general scientific sessions are planned for the convention. They will concern human sexuality; physical fitness and aging; impact of medical education on patient care; and chronic pulmonary insufficiency and air pollution problems.

Each of the AMA's 23 scientific sections will have its own program.

The Section on Special Topics plans six sessions: Drug Utilization (in cooperation with the AMA Council on Drugs); Mental Health Dynamics in the Pre-School Child (in cooperation with the Council on Mental Health); Disaster Planning for Aviation Accidents (in cooperation with AMA's Committee on Disaster Medical Care); Neurological Surgery; Nuclear Medicine; and Plastic and Maxillofacial Surgery.

Other Scientific Features

In addition to papers and lectures, there will be exhibits, closed circuit color television and medical motion pictures.

More than 250 scientific exhibits will be on display at the Coliseum, including special ones on arthritis, pulmonary function, fresh tissue pathology, fractures, resuscitation, and laboratory medicine.

The entire scientific program was published in the May 26 issue of *The Journal of the American Medical Association.*

Installation of AMA President

One of the highlights of the convention will be the installation of Dr. Gerald Dorman of New York City as President of the AMA. He will succeed Dr. Dwight L. Wilbur of San Francisco.

West Virginia Hospitality Suite In New York City

West Virginia physicians and their wives are cordially invited to visit the hospitality suite of the West Virginia State Medical Association during the Annual Convention of the American Medical Association in New York City in July.

The suite will be in the Americana Hotel, and the room number will be posted on the bulletin board in the lobby. The suite will be open from 5 to 7 P.M. on Sunday, Monday and Tuesday evenings, July 13-15.

If you plan to attend the AMA Convention, make it a point to drop by the West Virginia Suite.

College of Cardiology Begins Audio Tape Program

The American College of Cardiology has moved to expand its continuing education program through a new audio tape service.

The audio tape journal program is called ACCESS (American College of Cardiology Extended Study Services). Subject material will include highlights of the College's annual scientific session and of the various postgraduate programs the College sponsors throughout the country.

The first tape was issued last month.

Any physician may subscribe to either of two plans. Plan A includes a series of 12 tapes and playback equipment for a rate of $90 for members of the College and $100 for nonmembers. Plan B includes tapes only for a subscription price of $55 and $65.

Additional information may be obtained by writing to ACCESS, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

Dr. Van Liere and Mrs. Brown Honored by PH Association

Dr. Edward J. Van Liere of Morgantown and Mrs. Katherine L. Brown of Charleston were presented awards for "Meritorious Service in Public Health" at a banquet held in connection with the 45th Annual State Health Conference in Charleston, May 7-9.

"Successful Innovations Today—Health care Tomorrow," was the theme of the three-day conference sponsored by the West Virginia Public Health Association in cooperation with the West Virginia State Department of Health.

Doctor Van Liere, Dean Emeritus and Professor Emeritus of Physiology at the West Virginia University School of Medicine, was honored for his many contributions to the field of public health during his career at the University.

Mrs. Brown, who has served for several years as Executive Secretary of the Public Health Association, received the "Citizen's Award." She is Administrative Assistant to the Director of the Health Department's Tuberculosis Control Division.

The awards were presented by Dr. N. H. Dyer, State Director of Health.

The speaker at the banquet was Dr. B. S. Brake of Clarksburg, Health Officer for the Harrison County Health Department.

Dr. Daniel Hamaty, Director of Medical Education at Charleston Memorial Hospital, was installed as President of the Association during the business meeting. He succeeds Mrs. Bernice L. Vance, R. N., of Clarksburg.

The keynote address at the opening session was delivered by Dr. Richard Magraw, Deputy Assistant Secretary for Health Manpower, Department of Health, Education and Welfare. His subject was "The National Scope of Innovation and Change in Health Matters."

Dr. Edward J. Van Liere (left) and Mrs. Katherine L. Brown were honored by the West Virginia Public Health Association during the annual meeting in Charleston, May 7-9. Dr. N. H. Dyer, State Director of Health, presented the awards.

Doctor Dyer served as Moderator of a panel discussion on "Innovations and Change in Environmental and Personal Health Care in West Virginia." The following physicians participated as panelists:

Dr. Charles E. Andrews and Dr. Ernest W. Chick of Morgantown; Dr. N. Allen Dyer of Bluefield; Dr. Daniel Hale of Princeton; and Dr. Sherl J. Winter of Beckley.

Dr. Daniel Hamaty of Charleston (second from left) was installed as President of the West Virginia Public Health Association during the 45th Annual State Health Conference in Charleston, May 7-9. Others pictured (left to right): Dr. B. S. Brake of Clarksburg, who was the after dinner speaker at the annual banquet on May 8; Mrs. Bernice Vance, R. N., retiring President; Dr. N. H. Dyer, State Health Director; and Dr. Richard Magraw of Washington, D. C., who gave the keynote address. Doctor Magraw is Deputy Assistant Secretary for Health Manpower of the Department of Health, Education and Welfare.

New Association Members

Dr. Ahmed Ali, Box 351, Ripley (Kanawha). Doctor Ali, a native of India, received his M. D. degree in 1958 from the Osmania Medical College in India. He interned at Kanawha Valley Hospital in Charleston and served residencies at that Hospital and at St. Bartholomew's Hospital in Rochester, Kent, England. His specialty is general surgery.

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Dr. M. F. Anwar, 600 6th Street, Moundsville (Marshall). Doctor Anwar, a native of Pakistan, received his M. D. degree in 1960 from King Edward Medical College in Pakistan. He interned at Albert Einstein Medical Center in Philadelphia and served a residency at University Hospital in Birmingham, Alabama. He was previously located in Fairmont. His specialty is opthalmology.

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Dr. Robert B. Armstrong, The Wheeling Clinic, Wheeling (Ohio). Doctor Armstrong, a native of Parkersburg, was graduated from West Virginia University and received his M. D. degree in 1959 from Jefferson Medical College, He interned at the United States Naval Hospital in Philadelphia and served residencies at that hospital and the Cleveland Clinic. He served as a Lieutenant Commander in the Medical Corps of the United States Naval Hospital in Portsmouth, New Hampshire. His specialty is internal medicine.

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Dr. Landelino C. Cabrera, Appalachian Regional Hospital, Man (Logan). Doctor Cabrera, a native of Cuba, received his M. D. degree in 1956 from the University of Havana. He interned at Kentucky Baptist Hospital in Louisville, and served residencies at Michael Reese Hospital, Jackson Memorial Hospital and Variety Children's Hospital. He was previously located in Cuba and his specialty is pediatrics.

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Dr. Jack E. Cox, Farmington (Marion). Doctor Cox, a native of Newark, New Jersey, was graduated from Temple University and received his M. D. degree in 1941 from Hahnemann Medical College. He interned at West Jersey Hospital in Camden and served as a Captain in the Medical Corps of the United States Air Force. He was previously located in Pennsylvania and is engaged in general practice.

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Dr. John L. Coyner, Fairmont General Hospital, Fairmont (Marion). Doctor Coyner, a native of Clover Lick, West Virginia, attended the two-year WVU School of Medicine and received his M. D. degree in 1959 from the Medical College of Virginia. He interned at the USPHS Hospital at Staten Island, N. Y., and served residencies at the VA Hospital in Richmond, Virginia, and Walter Reed General Hospital in Washington. He served for two years as a Major in the Medical Corps of the United States Army and previously served as a member of the faculty at the Medical College of Virginia. His specialty is radiology.

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Dr. Simeon Lopez de la Cruz, Box 589, Weirton (Hancock). Doctor de la Cruz, a native of the Philippines, received his M. D. degree in 1950 from the University of Santo Tomas. He interned at Yonkers General Hospital in Yonkers, New York, and served residencies at New York Polyclinic Medical School and Hospital and St. Joseph's Hospital in Philadelphia. He was previously a member of the staff at Mt. Wilson State Hospital in Baltimore and his specialty is urology.

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Dr. Dominador G. Ignacio, Franklin Road, Walton, N. Y. (Logan). Doctor Ignacio, a native of the Philippines, received his M. D. degree in 1957 from the University of Santo Tomas. He interned at Overlook Hospital in Summit, New Jersey, and served residencies at Sacred Heart Hospital in Allentown, Pennsylvania, and Columbia Hospital for Women in Washington, D. C. His specialty is obstetrics and gynecology.

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Dr. Donald M. Koppel, Fairmont Clinic, Fairmont (Marion). Doctor Koppel, a native of Chicago, was graduated from the University of Illinois and received his M. D. degree in 1949 from the University of Illinois School of Medicine. He interned and served a residency at Cook County Hospital in Chicago. He served as a Captain in the Medical Corps of the United States Air Force and was previously located in Chicago. His specialty is internal medicine.

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Dr. Pedro J. Obregon, Pt. Pleasant Medical Center, Pt. Pleasant (Mason). Doctor Obregon, a native of the Philippines, received his M. D. degree in 1960 from Far Eastern University. He interned at St. Elizabeth Hospital in Elizabeth, New Jersey, and served residencies at Mt. Sinai Hospital in Milwaukee, and Norwegian American and Illinois Masonic hospitals in Chicago. His specialty is general surgery.

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Dr. P. V. Parilla, 10 Church Street, Cameron (Marshall). Doctor Parilla, a native of the Philippines, received his M. D. degree in 1960 from Far Eastern University. He interned at St. Elizabeth Hospital in Elizabeth, New Jersey, and served residencies at Princeton Hospital, St. Mary's Hospital, B. S. Pollak Hospital and Brooklyn Jewish Hospital. He is engaged in general practice.

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Dr. Paul B. Patton, VA Hospital, Clarksburg (Harrison). Doctor Patton, a native of Latrobe, Pennsylvania, was graduated from Pennsylvania State University and received his M. D. degree in 1935 from the University of Pennsylvania School of Medicine. He interned and served a residency at the University of Pennsylvania Hospital. He served as a Major in the Medical Corps of the United States Air Force during World War II and was previously located at Morristown, New Jersey. His specialty is internal medicine.

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Dr. Alfred J. Vincent, 800 Wheeling Avenue, Glen Dale (Marshall). Doctor Vincent, a native of New Zealand, received his M. D. degree in 1954 from the University of New Zealand School of Medicine. He interned at Timaru Hospital in New Zealand and served residencies at Dynedin and Nation Womens hospitals, both in New Zealand. He previously was located in Elkins and his specialty is obstetrics and gynecology.

2,000 Members To Attend Auxiliary Meeting

More than 2,000 members are expected to convene in New York City for the 46th Annual Convention of the Woman's Auxiliary to the American Medical Association. Headquarters for the July 13-17 meeting will be the Waldorf-Astoria Hotel.

Features of the meeting will include speakers on safety, violence and health care; presentation of the American Medical Association Education and Research Foundation awards; and a "show and tell."

The Board of Directors will meet on Saturday morning, July 12, and the registration desk will open on Sunday.

A reception honoring the President, Mrs. John M. Chenault of Decatur, Alabama, will be held from 5 to 7 P.M. on Sunday. Mrs. Chenault, previously President Elect, assumed the presidency in April following the death of Mrs. C. C. Long of Ozark, Arkansas (see story elsewhere in this issue of *The Journal.*)

The formal opening of the convention will be on Monday morning, July 14. Ethel J. Alpenfels, Ph.D., New York University anthropology professor, will deliver the keynote address entitled "The Anthropologist Looks at Health in a Changing Culture."

On Tuesday morning, James Ray Adams, Ph.D., Associate Director for Safety Research, Continental Research Institute, will discuss "Bending Elbows and Bending Twigs."

Ann Landers, nationally syndicated advice columnist, will speak at a luncheon on Tuesday honoring past presidents, officers, directors and committee chairmen.

The Wednesday morning session will include reports of officers, installation of officers and directors and other ceremonies. The postconvention planning session will be held that afternoon, at which time Dr. Ernest B. Howard, Executive Vice President of the AMA, will speak on AMA activities.

On Thursday morning, July 17, Mrs. Chenault will meet with the new Board of Directors.

The Auxiliary also will sponsor a program for preteens and teenagers who are in New York with their parents.

ACP Lists Three June Courses

Three postgraduate courses this month will complete the 1968-69 program of the American College of Physicians.

Courses, dates and locations are as follows:

June 9-13—"Neurology and the Internist"—Winston-Salem, North Carolina.

June 16-19—"Valvular Heart Disease, the Basis for Selecting Treatment"—Portland, Oregon.

June 16-20—"Hematology for Internists with Emphasis on Recent Advances"—Rochester, New York.

Tuition fees are $60 for members of the ACP and $100 for nonmembers.

Additional information may be obtained by writing to: Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

These members were active participants in the Spring Board Meeting of the Woman's Auxiliary to the West Virginia State Medical Association, which was held in Wheeling in April. Left to right: Mrs. Joe N. Jarrett of Oak Hill, President Elect of the Auxiliary; Mrs. John A. B. Holt of Charleston, President; and Mrs. Robert O. Strauch of Wheeling, President of the Woman's Auxiliary to the Ohio County Medical Society and Chairman of Arrangements for the Spring Board Meeting.

Woman's Auxiliary Conducts Spring Board Meeting

The Annual Spring Board of Directors Meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held in Wheeling in April.

The sessions were attended by more than 40 state officers, committee chairmen and officers of component Auxiliary units.

Mrs. John A. B. Holt of Charleston, President, conducted the business session, which included reports of officers and committee chairmen. Mrs. Joe N. Jarrett of Oak Hill, President Elect, announced that a new Auxiliary unit had been organized in Mason County.

Mrs. Wilson P. Smith of Huntington, Regional Chairman for AMA-ERF, was introduced. She spoke on the importance of the Auxiliary's continued support of the program.

Mrs. Jarrett served as Moderator for a panel discussion of Auxiliary programs at a workshop for all officers and chairmen. Panelists included: Mrs. Robert G. Janes, Community Service; Mrs. Robert Fleming, Mental Health; and Mrs. B. F. Puckett, Safety-Disaster Preparedness.

The Woman's Auxiliary to the Ohio County Medical Society hosted a banquet which was held at Wilson Lodge, Oglebay Park. Mrs. Robert O. Strauch served as Chairman for the banquet.

Film for Professional Groups Released by Sandoz

"The Scream Inside . . . Emergence Through Group Therapy," is a new psychotherapy film recently made available for qualified professional audiences by Sandoz Pharmaceuticals.

The film presents a wide range of psychotherapeutic group processes and dynamics on many levels, with actual therapy sesions photographed or videotaped. Patient conversation is free of restrictions on subject matter or vocabulary. The purpose of this film is to communicate concepts basic to an understanding of therapeutic group functions and objectives.

It may be obtained for showing by addressing a request to Medical Film Department, Sandoz Pharmaceuticals, Route 10, Hanover, New Jersey.

PG Course for ER Nurses In Chicago

A Postgraduate Course for Emergency Room Nurses will be held at the Palmer House in Chicago, September 25-27. The seminar is sponsored by the Chicago Committee on Trauma of the American College of Surgeons.

Dr. George T. Anast, Program Chairman, said about 1,000 nurses can be accommodated. The curriculum will include formal lectures, audio-visual presentations and a series of seminars to give nurses an opportunity to pursue various subjects of particular interest.

Advance registration is required and should be accompanied by the tuition fee of $60, which covers three full days of scientific sessions and the chairman's reception and banquet. Registration fees and inquiries should be sent to Doctor Anast at 55 East Washington Street, Chicago, Illinois 60602.

Medical Association Moves To New Office

The Headquarters Office of the West Virginia State Medical Association has moved.

On May 23, the Office was moved to 1526 Charleston National Plaza, on Capitol Street in Charleston between Virginia Street and Kanawha Boulevard. For many years the Headquarters Office was located in the Atlas Building on Quarrier Street.

The Association's mailing address will remain Post Office Box 1031, and the telephone number (346-0551) remains unchanged.

These physicians had key roles in the National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, which was held at The Greenbrier in White Sulphur Springs, April 20-23. Left to right: Dr. James T. Spencer of Charleston, Program Chairman for Otolaryngology; Dr. Albert C. Esposito of Huntington, Program Chairman for Ophthalmology; Dr. Edward Shupala of Parkersburg, President of the Academy; Dr. Nime K. Joseph of Wheeling, a Director; and Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer.

Child Health Care Meeting In Philadelphia

A Regional Conference on the Delivery of Health Care to Children will be sponsored by the American Academy of Pediatrics this month.

The conference, one of a series of such meetings sponsored by the Academy, will be held at the Marriott Motor Hotel in Philadelphia, June 20-21. Dr. W. Gene Klingberg of Morgantown, Professor and Chairman of the Department of Pediatrics at the West Virginia University Medical Center, is Program Chairman for the Conference.

W. Gene Klingberg, M. D.

The Academy has embarked on a two-year project to examine and interpret the present status of the delivery of health care to children and the important forces influencing it; to develop a forecast of future needs in child health care; and to prepare a report of proposed new or improved techniques and systems for providing this care.

Doctor Klingberg said the program for the conference will include presentations on the availability of comprehensive health care for children in urban and rural areas, the health needs of the public as seen by the consumer and by the physician, health education of the public as seen by the consumer and by the physician, health education of the public, the medical education process, as well as a thorough review of the advance in the delivery of care via the private office and hospital practice.

Better Health Care Linked To Education System

To provide better medical care and produce more health workers there must be drastic changes in U. S. colleges and universities, representatives of state medical societies' liaison committee with nursing were told at a recent meeting in Chicago.

Darrel J. Mase, Ph. D., Dean, College of Health Related Professions, University of Florida, assailed colleges and universities as "the most archaic institutional structures in society. Tradition is our greatest deterrent to change, and tradition exists in our education and health institutions as well as in the people who make up the institutions."

Doctor Mase spoke at the Second National Conference sponsored by the American Medical Association's Committee on Nursing. Theme of the conference was: Meeting the Challenge of Change in the Delivery of Health Care Services.

Forty-four state representatives met with members of the Committee and its panel of nurse consultants. Their goals were to consider causes which demand changes in the delivery of health care services, delineate the shifting role of physicians and nurses, consider education required to prepare nurses for a changing role, encourage state-wide conferences based on the national AMA-American Nursing Association conferences, and to provide the AMA Committee on Nursing with a comprehensive view of what is being done at the state level in the delivery of health care services.

"We are going to have to do a far more imaginative and aggressive job of renewing, redesigning, and revitalizing our institutions if we are to meet the requirements of today," he said. "These are among the thoughts which make me pessimistic about the isolated and abortive attempts to redefine, redelegate, reassume functions of the physician and the nurse."

Two physicians and two dentists who had prominent roles in the Annual Spring Meeting of the West Virginia Chapter, American Academy of Pediatrics, are shown in picture at left. They are guest speakers H. E. Kiser, Jr., D. D. S., of Bluefield; Jacqueline Noonan, M. D., of Lexington, Kentucky; Stanley Poleway, D. D. S., of Charleston; and Meryleen B. Smith, M. D., of Peterstown, Chairman of the Program Committee. State School Supt. Rex M. Smith (center in right picture) was after dinner speaker at the banquet held in conjunction with the pediatric meeting. He is flanked by State Health Director N. H. Dyer of Charleston and Dr. Forest A. Cornwell of Beckley, Chairman of the State Chapter. The meeting was held in Princeton, April 10-11.

Water Fluoridation Discussed In Health Bulletin

The "State of the State's Health," published by the State Health Department, in its April 9 issue pointed up the great benefits of public water fluoridation. Water fluoridation has earned equal stature with three other big public health measures; pasteurization of milk; chlorination of water, and immunization. Few problems are as easy to resolve as fluoridation, if fluoridation has the support of the community's public officials. Compared with air pollution, sewage disposal, juvenile delinquency, urban renewal and dozens of other problems, fluoridation is strikingly simple. It is beneficial, inexpensive, safe and easy to engineer.

It cannot be emphasized too strongly that communities in West Virginia which are lacking the proper levels of health-giving fluorides in their public water supplies proceed hastily toward establishing controlled water fluoridation according to the Health Department. West Virginia ranks twelfth in the nation with respect to percentage of people drinking public water who have benefits of fluoridated water. The percentage is 79.4. One hundred fifty-nine West Virginia villages, towns and cities are reaping the rewards afforded them by fluoridated water.

In the April 30 issue of "State of the State's Health," it was reported that a unique collaboration has been formed between the West Virginia State Department of Health, Bureau of Heart Disease Control and the Mount Sinai Medical Center and the Chromalloy American Corporation in New York, for the purpose of automatically analyzing and diagnosing electrocardiograms.

Dr. N. H. Dyer, State Director of Health, will direct the project for West Virginia with Doctor Harold Selinger, Interim Director of the Bureau of Heart Disease Control, supervising the study.

A portable electrocardiograph cart, especially designed for computer transmission has begun a tour of week-long stays at approximately forty (40) interested hospitals throughout the State. The tour began with Thomas Memorial Hospital in South Charleston on April 14. Another cart is stationed at Princeton Memorial Hospital to evaluate its use and effectiveness on a permanent basis in a small hospital.

Computerized ECG interpretations have the following advantages:

1. It makes excellent ECG interpretation available anywhere there is a telephone.
2. It makes time available for the busy cardiologist. This method of ECG interpretation frees him from routine cardiogram reading chores and thereby enables him to spend more of his time in the care and treatment of cardiac patients.

If the experiment proves successful, a computer center located in Charleston would process incoming cardiographic data transmitted by telephone or mailed by physicians from hospitals and offices throughout the State.

Looking Back 10 Years . . .

This Committee studied resolutions which were submitted during the State Medical Association's Annual Meeting of 1959. Members of the Committee were (left to right): Dr. Maynard P. Pride of Morgantown, now President Elect of the Association; Dr. Richard W. Corbitt of Parkersburg, the current President; Dr. G. Thomas Evans of Fairmont; Dr. Albert C. Esposito of Huntington, who served as President of the Association in 1964-65; Dr. Pat A. Tuckwiller of Charleston; and Dr. Charles L. Leonard of Elkins.

Improved Child Health Care Sought by Commission

The Joint Commission on Mental Health of Children is recommending a broad program aimed at bettering the health of the nation's children and youths at an estimated cost of $6 billion to $10 billion a year.

The Commission recently disclosed its recommendations to the annual meeting of the American Psychiatric Association in advance of its report to Congress. The 54-member commission—which has completed a three-year, $1.5 million study—was established by Congress in 1965.

Sen. Abraham A. Ribicoff (D., Conn.), who introduced the legislation to set up the Committee, said he would promptly introduce legislation to carry out the commission's recommendations.

The recommendations included national health insurance for persons up to 21 or 25 years old; family planning and birth control; prenatal care; pediatric care for children up to age of three, and physical and mental health services for older children.

Among other recommendations was one calling for federal funding for about 100 child development councils to help guide families through the confusion of Government agencies in order to insure diagnostic, treatment and preventive services for children.

Doctor Tully Is President Of AAGP Chapter

Dr. C. Carl Tully of South Charleston has assumed duties as President of the West Virginia Chapter of the American Academy of General Practice.

Doctor Tully was installed during the Chapter's Annual Scientific Assembly, which was held in April in Wheeling. He succeeds Dr. Del Roy Davis of Kingwood, who will serve as Chairman of the Board of Directors for the coming year.

Dr. James E. Spargo of Wheeling was named President Elect. He will assume the presidency during the 1970 meeting in Charleston next April 24-26.

Other Chapter officers for the coming year include: Dr. Joe N. Jarrett of Oak Hill, Vice President; Dr. J. H. Wolverton of Piedmont, Secretary; Dr. Richard E. Flood of Weirton, Treasurer; and Drs. Carl B. Hall and J. Keith Pickens of Clarksburg, Delegates to the American Academy of General Practice convention.

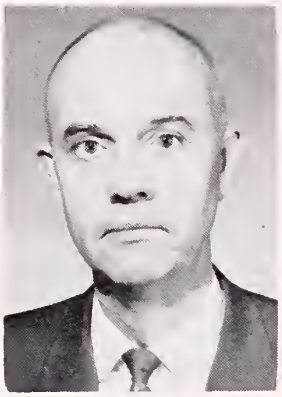
1.7 Million Have Glaucoma

More than 1,702,000 Americans over the age of 35 have glaucoma and half of them do not know it, according to the National Society for the Prevention of Blindness.

The Committee on Medical Scholarships met in Morgantown April 12-13 to interview applicants for the 1969 State Medical Association scholarships and to make the awards. Seated: Dr. Richard W. Corbitt of Parkersburg, President of the State Medical Association; Dr. Martha J. Coyner of Harrisville, Chairman of the Committee; and Dr. Clark K. Sleeth of Morgantown, Dean of the West Virginia University School of Medicine. Standing: Dr. John Mark Moore of Wheeling; Dr. Russel Kessel of Charleston; Dr. Thomas J. Holbrook of Huntington; Dr. Robert D. Hess of Bridgeport; and Dr. Marshall J. Carper of Charleston.

Tygart's Valley Society Lists Annual Scientific Session

The Annual Scientific Meeting of the Tygart's Valley Medical Society will be held on June 19 at Tygart Lake State Park near Grafton.



Jim Comstock

Golfing will begin at 7:30 A. M., and a Symposium on Trauma is to start at 2 P. M. The Moderator will be Dr. B. R. Blackburn of Elkins, and the speakers and their topics will be as follows:

"Trauma of the Chest" —Herbert E. Warden, M.D., Professor of Surgery, West Virginia University School of Medicine, Morgantown.

"Cranio-Cerebral Trauma"—G. Robert Nugent, M. D., Associate Professor of Neurosurgery, West Virginia University School of Medicine, Morgantown.

"Blunt Trauma to the Abdomen"—Dave Clare, M. D., Pittsburgh, Pennsylvania.

"Orthopedic Problems of Trauma"—Patrick G. Laing, M. D., Pittsburgh, Pennsylvania.

There will be a social hour at 5 P. M., followed by dinner at 6:15. The Moderator for the evening program will be Dr. Donald R. Roberts of Elkins, and the featured speaker will be Mr. Jim Comstock, Editor of *The West Virginia Hillbilly.*

Mr. Comstock will speak on "Ramblings of a West Virginia Hillbilly Editor."

Additional information may be obtained by contacting Dr. A. Kyle Bush, Secretary, Tygart's Valley Medical Society, The Myers Clinic, Philippi, West Virginia 26416.

Health Care Is Becoming Largest 'Industry'

By 1975 health care is expected to be the nation's largest "industry" in terms of expenditures and employees, says the Health Insurance Institute.

Government projections indicate that there will be 5.3 million men and women working in this field by 1975. At that time our national health bill will probably reach an all-time high of $94 billion.

Today, health care ranks third in workers after agriculture and construction. It is also one of the top purchasers of goods and materials, along with industries like automobile manufacturers, steel and other makers of basic products.

Last year the total national health bill was $51 billion—$6 billion higher than the previous year. This includes everything connected with health, from doctors' fees to private health insurance premiums.

Auto industry statisticians value the size of their industry at $50 billion, including all related services.

At present, health care accounts for about six per cent of the gross national product. Of this about two-thirds is generated in the private sector; the remainder is government spending, much of it through Medicare, Medicaid, aid for research and construction, etc.

Current predictions are that by 1975 health care's share of the GNP might reach 7 per cent.

Charges for medical care, which have risen consistently during the post-World War II period, have been an important factor.

The Department of Labor points out that in the 21 years following World War II—the period from 1946 to 1967—the medical care component of the Consumer Price Index has increased 125 per cent equivalent to an annual rate of 3.9 per cent. Prices of all consumer items combined rose at a rate of 2.6 per cent a year.

Dr. Richard A. Currie of Morgantown (left), retiring President of the West Virginia Chapter, American College of Surgeons, is shown with new officers of the Chapter during the group's spring meeting at The Greenbrier in April. Others are (left to right): Dr. John W. Trenton of Kingwood, President; Dr. Herbert G. Dickie, Jr., of Wheeling, Vice President; and Dr. David B. Gray of Charleston, Secretary-Treasurer.

102nd ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 21-23, 1969

PLAN NOW TO ATTEND

Dr. Richard W. Corbitt of Parkersburg (center), President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Logan County Medical Society, which was held at the Woman's Club in Logan on April 23. With Doctor Corbitt are Dr. John R. Wilkinson, Jr., of Man (left), President of the Logan County Medical Society, and Dr. Sergio A. Payuyo of Logan, Secretary-Treasurer.

Experimental Pathologists Honor Scripps Scientist

A California immunopathologist has received the $1,000 award and a gold medal given annually by the American Society for Experimental Pathology to a member under 40 who has made the most outstanding contribution to the conquest of disease.

Dr. Charles G. Cochrane, 38, of La Jolla, California, was honored during the Society's 57th Annual Meeting in Atlantic City for discovering and explaining the exact sequence of bodily processes at a basic level that may be important in diseases such as glomerulonephritis, rheumatic fever, rheumatoid arthritis, inflammation of arteries and multiple sclerosis.

Immunological processes resulting from antigen-antibody complexes appear to be actively involved in most if not all of these diseases.

Doctor Cochrane has not only pinpointed a number of the exact steps in the antigen-antibody reaction that lead to disease. He has also, with the help of associates in the Scripps Clinic and Research Foundation, demonstrated that these steps can be circumvented to prevent such disease in experimental animals. These findings have already been shown to have important clinical significance for the prevention of immunologic diseases in man and for improving the outlook for transplants.

The ASEP's retiring president, Dr. Henry D. Moon, of San Francisco, made the presentation.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

June 9-11—Am. Neurological Assn., Los Angeles.
June 23-26—Am. Orthopaedic Assn., Hot Springs, Va.
June 28-29—Am. Diabetes Assn., New York.

July 2-7—Int. Col. of Surg., Lake Placid, N. Y.
July 13-17—AMA, New York.
July 18-19—Rocky Mtn. Cancer Conference, Denver.

Aug. 18-21—Am. Hosp. Assn., Chicago.
Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.

Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.

May 5-9—Am. Psychiatric Assn., San Francisco.
May 11-14—Am. Urological Assn., Philadelphia.
May 18-22—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.

June 21-25—AMA, Chicago.

The West Virginia Medical Journal

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Cancer Palliation by Solid Tumor Chemotherapy (Part II)

Alvin L. Watne, M. D.

Table 5 lists the therapy we most frequently utilize and the results we may expect from patients with various adenocarcinomas of the gastrointestinal tract. Little if any benefit has been seen by us, nor reported in the literature, for squamous cell carcinoma of the esophagus, and various leiomyosarcomas, liposarcomas or fibrosarcomas of the stomach or bowel. Lymphosarcoma of the bowel can be treated by radiation or chemotherapy, or both, similar to lymphosarcoma of other areas and will not be considered in the scope of this paper.

This is the second in a series of three articles by Doctor Watne which are being published in consecutive issues of The Journal.

In July of 1962, Ansfield[25] et al reported their five years' experience utilizing 5-fluorouracil in various tumors including those of the gastrointestinal tract. They reported an objective regression for 25 per cent of cases of stomach cancer, no regression in six cases of pancreatic cancer, and regression in 15 per cent of cases of cancer of the colon and rectum. These observers used the 15 mg./kg. dosage schedule, repeating the course of therapy every 30 days if tolerated. Moertel and Reitemeier[26] reviewed the literature and reported their experience. The literature review revealed objective remissions in 24 per cent of cases of stomach cancer, 30 per cent of cases of pancreatic cancer, and 28 per cent of cases of colon cancer. Their own experience showed objective regressions in 20 per cent of cases of stomach cancer, 12.5 per cent of cases of pancreatic cancer and 20 per cent of cases of colon cancer. Rochlin,[27] using a maintenance dosage schedule, reported objective responses in 28 per cent of cases of stomach cancer, 41 per cent of cases of pancreatic cancer, and in 40 per cent of cases of cancer of the colon.

The Author

- **Alvin L. Watne, M. D., Professor of Surgery, Charleston Foundation Chair of Cancer Research, West Virginia University Medical Center, Morgantown.**

Our own experience shows 47 per cent excellent and another 35 per cent partial response for patients with colon cancer but none for stomach or pancreatic cancer. We favor the maintenance dosage schedule for prolonged remissions. After the initial loading dose of 12 mg./kg. daily for five days followed by half doses every two days[28], we administer 500-1000 mg. intravenously once or twice weekly depending upon the patient's clinical status and the response of the disease. We do not continue the maintenance dosage if the carcinoma again shows signs of progression.

Unlike the alkylating agents, however, we have seen objective tumor regression following repeated adequate dosages of 5-fluorouracil, and do not hesitate to use it again and again.

Table 5

Gastrointestinal

Tumor	Drug(s)	Response	Duration
Stomach	5-FU	20-28%	1-3 mo.
Pancreas	5-FU	0-41%	1-3 mo.
Colon & Rectum	5-FU	15-48%	3-9 mo.
Liver & Biliary Tract	5-FU (I.V.)	10%	1-3 mo.
	MTX. & CF (I.A.)	(50%)	1-3 mo.
	5-FU } I.A.	60%	2-18 mo.
	5-FUDR }		

A variation in 5-fluorouracil administration was put forward by Lemon,[29] in 1960, when he reported the decreased toxicity associated with prolonged intravenous infusions. The resulting controversy was laid to rest by a carefully controlled study by Reitemeier and Moertel[30] who demonstrated that the slow eight-hour intravenous infusion was less toxic than the rapid intravenous push method, but also was less effective in inducing objective remissions. Likewise, any variance in opinion about the efficacy of administration of 5-fluorouracil in glucose or saline was resolved by Cressy and Schell,[31] who showed that it didn't make any difference.

Liver and Biliary Tree

A lesser number of patients are available for evaluation for tumors of the liver and biliary tree. Brennan[32] et al report a 10.5 per cent regression rate in 19 cases of cancer of the liver or gallbladder when treated with 5-fluorouracil intravenously. In their inclusive study the authors point out that treatment with 5-fluorouracil is associated with a 10 per cent mortality rate, primarily in cases of debilitated patients, and gives a mean duration of regression of seven months. Ansfield[25] reported two of four hepatomas responding, while Rochlin[27] saw no response in three gallbladder carcinoma patients. Field[33] showed objective responses in one of two cases of hepatoma and in two of four cases of biliary tract cancer.

Sullivan[34] et al, in 1959, described the intra-arterial tumor infusion of large doses of methotrexate with systemic protection by its antagonist, folinic acid.

Drug Not Available Commercially

This group,[35] in 1964 reported their experience with hepatic artery infusion for metastatic liver tumors, using primarily 5-fluorouracil or 5-fluoro-2-deoxyuridine. The latter drug is extremely effective, but is expensive, in short supply, and not available commercially. Sullivan reported complications with the transabdominal catheterization technique in four of his 21 patients, and his tumor response lasted from two to 12 months. In a recent review, Sullivan[36] et al report that in 60 per cent of cases of primary or metastatic liver cancer there was sustained remission of disease for as long as 18 months. Burrows[37] et al have reported a 59 per cent regression rate of metastatic gastrointestinal malignancies by hepatic artery infusion of 5-flourouracil or 5-fluoro-2-deoxyuridine via a transbrachial hepatic artery catheterization technique. They still had a 20 per cent incidence of catheter displacement. Our own experience[38] is limited but we observed objective remissions in two cases of hepatoma and in one of four cases of metastatic disease; but the remissions were of short duration. Our feeling is that this is a difficult and hazardous method of cancer chemotherapy. The generally brief remission time and numerous technical difficulties should limit its application to experienced, skilled oncologists. For general application, we would use an intravenous technique, recognizing its limitations.

Urologic Tumors

Table 6 lists some of the urologic tumors and their recommended chemotherapy. Metastatic adenocarcinoma of the adult kidney has not been extensively studied using anticancer drugs. Arduino,[39] in a review of the problem, reported that actinomycin D had been of some benefit and that in two of five cases in his series there had been response to cyclophosphamide. Shnider[40] et al reported no benefit from cyclophosphamide in six cases of kidney cancer. Arduino pointed out that hypernephroma does not respond to 5-fluorouracil, and such has been our experience.

Table 6

Urologic Tumors

Tumor	Drug(s)	Response	Duration
Kidney			
Adenoca.	Cytoxan	(40%)	6-17 mo.
Wilms'	Actino. D	35%	10-35 mo.
	Actino. D Adj.	89%	4 yr.
	Vincristine Adj	(100%)	5-21 mo.
Pelvis & Ureter (Trans. Cell)	Cytoxan	(100%)	3 yr.
Bladder (Papillary)	TSPA (Intravesical)	61%	1.5-18 mo.
Prostate	Diethystilbesterol (Orchiectomy)	21%	5 yr.

Wilms' Tumor

Treatment of Wilms' tumor in children is a different story. Farber[41] et al, in 1960, reported their experience in palliation of Wilms' tumor with actinomycin D and x-ray therapy. In 35 per cent of cases, the patients were cancer free 10 to 35 months after onset of symptoms. During the same time period eight children with advanced Wilms' tumor were not treated and they died. The authors presented their preliminary results using x-ray therapy and actinomycin D as adjuvant therapy to surgery for the primary tumor. Their use of the drug has received sophisticated evaluation and the recent report of Burgert and Glidewell[42] represents the present-day thinking. Patients receiving the drug on the day of surgery had the greatest advantage in survival, 24 of 27 (89 per cent) were alive four years after operation. Of eight patients receiving the drug prior to surgery, four were

alive at three years, and of 14 (35 per cent) receiving the drug during the first week after surgery, five were alive four years later. Over one-half of the patients received additional courses of actinomycin D. Additional stimulus to this problem was given by the recent report of Sullivan[43] et al who used vincristine preoperatively and postoperatively in the cases of four children with inoperable unilateral Wilms' tumor. All four children were living and free of disease five to 21 months after treatment.

Little specific data are available regarding chemotherapy for transitional cell carcinoma of the renal pelvis or ureter. Glenn[44] reported a complete remission for three years in the case of a patient treated with cyclophosphamide.

Jones and Swinney,[45] in 1961, reported on the use of thiotepa in treating bladder tumors by instillation directly into the bladder. They selected patients with multiple papillary tumors with no clinical evidence of infiltration. They gave up to 400 mg. total dose divided over eight to 14 days, the 50 ml. solution of drug being retained for three hours. In eight of 13 cases, the patient had almost complete disappearance of papillary tumors, and some palliation was achieved in the cases of invasive carcinoma. Veenema[46] et al reported similar results with the stage A lesions and showed that most of the thiotepa was polymerized into an active state after two hours in the bladder. They presented one case, however, in which marked leukopenia developed when the drug remained in the bladder for seven hours. The patient had an advanced tumor and probably a high surface absorption. Wescott[47] recently reported on the exciting concept of the prophylactic use of thiotepa in bladder cancer. His preliminary results are encouraging in 14 cases of low stage neoplasm. In many of these cases, the patient had multiple recurrences prior to treatment, but none developed with the monthly instillation of the drug.

Carcinoma of Prostate

Hormonal control of prostate carcinoma developed from the pioneer work of Huggins.[6] Nesbit and Baum,[48] in 1950, reported on a cooperative group of prostate cancer patients. In the cases of 587 patients treated by various means, nine per cent of the control group receiving no therapy survived for five years, while 18 per cent of those receiving diethylstilbesterol, 26 per cent of those undergoing orchiectomy, and 36 per cent of those having orchiectomy and receiving diethylstilbesterol survived for five years. More recently Emmett[49] et al reported that stilbesterol was an effective treatment alone, giving a 21.4 per cent five-year survival rate in patients with metastases, which was somewhat better than orchiectomy alone in these cases. The stage of the disease complicated evaluation. For early cancer without metastases, orchiectomy alone gave the best survival rates, and the use of stilbesterol had little influence.

VA and Estrogen Therapy

Recent reports by the Veterans Administration Co-Operative Urological Research Group[50,51] have opened a question regarding estrogen therapy. While the estrogen therapy did cause a modest decrease in the mortality rate of prostatic cancer, these patients showed a substantial increase in mortality from other causes, primarily heart disease and cerebrovascular accident. The group also concluded that estrogen therapy or orchiectomy should be withheld until the patient's symptoms required relief. These reports must be carefully evaluated and the problem reassessed as outlined by Prout[52] in a recent editorial.

Endocrine Organs

The application of chemotherapy to the treatment of tumors of some of the endocrine organs is shown in Table 7. Balme,[53] in 1954, reported regression of thyroid cancer in a case in which the patient was treated with sodium 1-thyroxine. Crile,[54] in 1955, reported five cases in which metastatic papillary carcinoma regressed with administration of desiccated thyroid.

Thomas,[55] in 1957, showed inhibition of tumor growth in four of nine cases of disseminated thyroid cancer treated with desiccated thyroid 120 to 300 mg. daily. He postulated the prophylactic value of this treatment by suppression of the action of the thyrotropic hormone in cases following surgical treatment of primary thyroid cancer. Crile[56] reported on the long-term follow-up of 19 cases of proven metastases from papillary thyroid cancer. In 12 cases, or 63 per cent, there was regression or arrest of metastases for five to 16 years, a truly remarkable palliation.

Other Treatment Methods

Bateman and Winship[57] reported that in 17 of 22 cases of metastatic ovarian carcinoma there was some type of objective response to treatment with an alkylating agent, triethylenethiophosphoramide. The response lasted from one to 11 months. Palliation in seven of their cases included a decrease in malignant effusions. Hreschchyshyn,[58] in a subsequent report, observed the malignant effusions to be controlled in 26 per cent and partially controlled in another 38 per cent of his cases in which the patient was treated with the intravenous or intracavitary instillation

of thiotepa. This drug remains a mainstay in our treatment of ovarian cancer, utilizing 0.2 mg. to 0.4 mg. per kg. of body weight into the peritoneal or pleural cavity for control of malignant effusions.

Masterson et al,[59] in 1960, reported on the use of chlorambucil in the treatment of ovarian carcinoma. The drug gave an excellent response in 20 per cent of cases, and a favorable response was observed in two-thirds of the cases.

Masterson,[60] in 1965, reported on the use of chlorambucil and several other drugs for ovarian cancer. The chlorambucil gave the best results, giving arrest or regression of the disease in 65 per cent of cases, and by using a maintenance dosage consisting of two to four-week courses of the drug with rest periods up to three weeks, these observers reported tumor remissions for over two years in 40 cases. They believed that the serous and mucinous cystadenocarcinomas were more sensitive to the drug. Numerous other drugs have been used in treating ovarian carcinoma, but the most encouraging report was a controlled study by Decker et al[61] in which cyclophosphamide resulted in arrest or remission of the disease in 15 per cent of 40 cases, lasting from three to 22 months. This effect was enhanced with irradiation. Thiotepa gave an objective response in six of 16 cases, and 5-fluorouracil gave no response in five. It would appear that the alkylating agents are specific for ovarian cancer, and we prefer chlorambucil because of its ease of administration, utilizing thiotepa more in ascites problems, and cyclophosphamide for the patient with resistant tumor.

The Reward

The scientific effort to utilize anticancer drugs to their greatest benefit came to a rewarding report by Li[62] and associates on testicular cancer, in 1960. By combining an alkylating agent, an antimetabolite and an antibiotic, they reported tumor regression in 12 of 23 cases. The drugs chlorambucil, methotrexate and actinomycin D proved the most effective. Whitmore[63] subsequently reported on a follow-up in these cases. Thirty-eight of 55 patients treated by the triple therapy showed an objective tumor response, including three patients with seminoma, 17 of 25 patients with embryonal carcinoma, 11 of 17 with teratocarcinoma and 7 of 10 with choriocarcinoma. Five patients were free of disease from nine to 75 months. We favor this extremely effective triple therapy regimen, consisting of a seven-day course of methotrexate, 5 mg. orally daily, chlorambucil 10 mg. orally daily and actinomycin D, 0.5 mg. intravenously daily for five days beginning on the third day. Generally the patient is given a 10-14 day rest before a subsequent course of therapy. The treatment is toxic but effective.

A New Interest

Interest recently has centered on the antibiotic Mithramycin for the treatment of embryonal cell carcinoma.[64] While this is an extremely effective drug, we have found it to be extremely toxic, as have others.[65] It still is an investigational drug, unavailable commercially, but may hold promise.

(To Be Continued)

Table 7

Endocrine Tumors

Tumor	Drug(s)	Response	Duration
Thyroid	Desiccated Thyroid	63%	5-16 yr.
Ovary	TSPA (I.V.)	26-77%	1-11 mo.
	TSPA (I.P.)	26%	3-6 mo.
	Chlorambucil	20-65%	0.5-2 yr.
	Cyclophosphamide	15%	3-22 mo.
Testes	Triple Therapy*	51%	9-75 mo.
Seminoma		(100)	
Embryonal		(68)	
Teratoma		(64)	
Choriocarcinoma		(70)	

*Chlorambucil, methotrexate, Actinomycin D

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Part II

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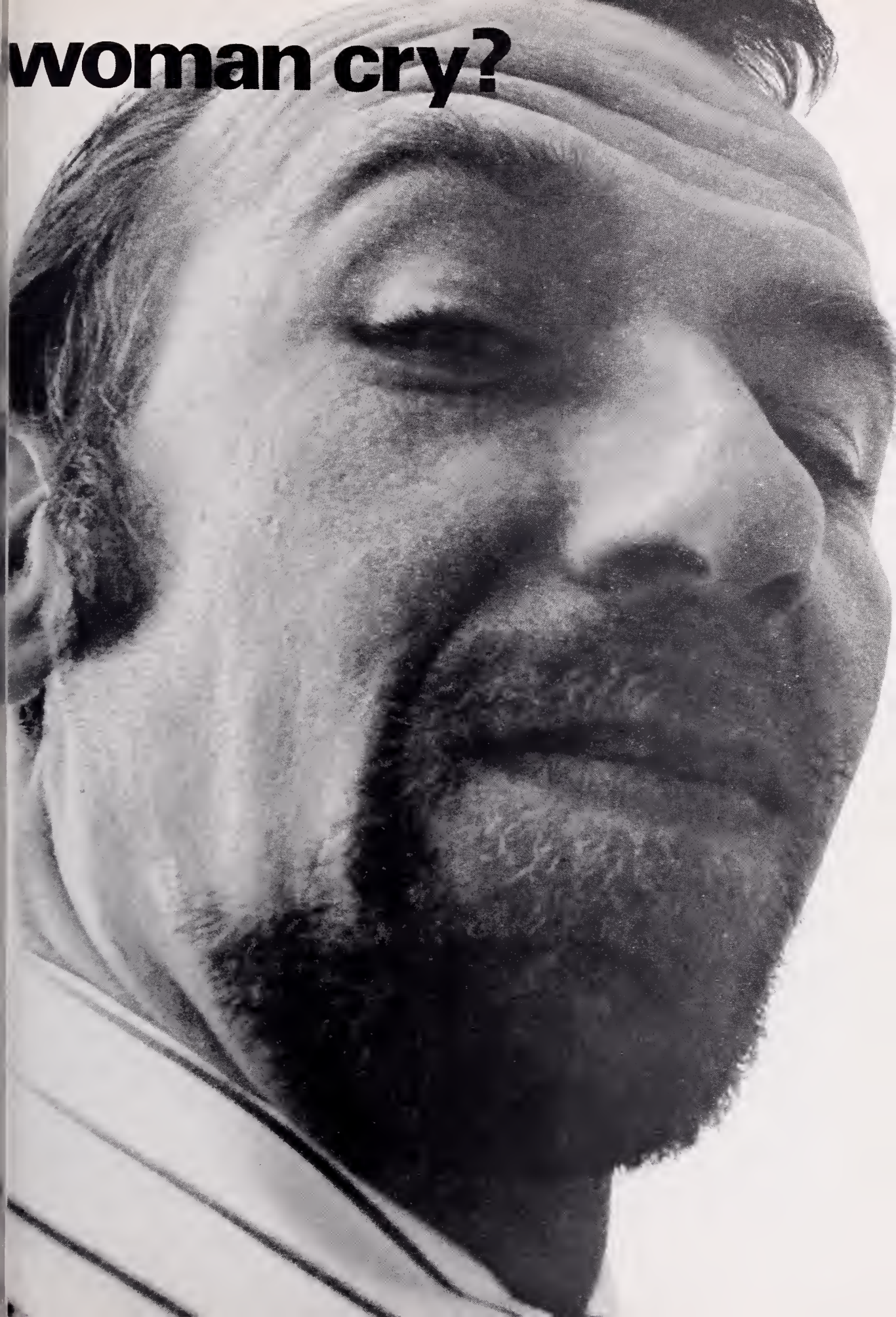

Cholangiojejunostomy for Sclerosing Adenocarcinoma Of the Common Duct

(An Unusual Case of Biliary Obstruction)

Siroos Gerami, M. D., George W. Easley, M. D., and Catalino B. Mendoza, Jr., M. D.

INTRAHEPATIC cholangiojejunostomy was described in 1948 by Longmire and Sanford[1,2] for relief of biliary tract obstruction due to destructive benign lesions of extrahepatic ducts. Waddell and Burbank[3] applied the same procedure for palliation of inoperable carcinoma obstructing the bile ducts at the hilus of the liver. In addition to prolongation of life, they achieved satisfactory relief of distressing symptoms after biliary drainage.

Sullivan and Faris[4] reported a case with extensive sclerosing adenocarcinoma of intrahepatic bile ducts in which a modified Longmire operation was utilized, avoiding mucosa-to-mucosa biliary-enteric anastomosis. They indicated their patient had an excellent palliation for 29 months.

We are reporting a case of advanced carcinoma of the common duct with high complete obstruction. The patient had an unusual dilatation of the biliary canaliculi on the surface of the liver. Palliation and decompression were achieved by a modified Longmire technique.

Case Report

A 76-year-old Caucasian male entered the Veterans Administration Hospital, Clarksburg, West Virginia, on October 16, 1967, complaining of painless jaundice and pruritis of about four weeks' duration. He did not present any criteria to indicate hepatitis and had no past history of jaundice. He complained of nausea, occasional vomiting and loss of appetite. He had lost about 25 pounds in a period of one month, and had noted clay-colored stools and brownish-yellow urine for about four weeks prior to admission. The patient stated he did not smoke or drink.

Physical examination revealed a very thin, poorly nourished, cachectic, elderly white male, appearing chronically ill. Pertinent positive findings were deep yellow sclera, mucosa and skin. The cardiopulmonary system was negative. Abdominal examination showed mild tenderness in the epigastrium and right upper quadrant area. On palpation and percussion, the liver appeared large, hard and lobulated, and was located about 15 cm. below the right costal margin. The spleen was not palpable. There were no palpable abdominal masses, bowel sounds were normal, and there was no bruit present. There were bilateral indirect, reducible, inguinal herniae.

Laboratory studies at time of admission revealed hemoglobin 11.8, hematocrit 35, white blood cells 12,000 with a normal differential count. BUN was 24 mg. per cent, two-hour postprandial blood sugar was 92 mg. per cent. Total protein was 6.5 Gm. per cent, with albumin 4 Gm. per cent and globulin 2.5 Gm. per cent. A/G ratio was 1.6:1. CO_2 combining power was 21.5 mEq per liter, chlorides 104, sodium 128, potassium 4.3 mEq per liter. Prothrombin time for patient was 16, for control 14. Amylase was 120 somogi units. Urinalysis was positive for bile.

On the day following admission, bilirubin was 6.8 mg. per cent, with total of 14.4 mg. per cent, and alkaline phosphatase was 30 sigma units. Chest x-ray and flat and upright views of the abdomen were negative. Upper GI series and IVP were normal.

Bilirubin rose up to the time of operation, to a maximal level of 11.2 mg. per cent direct, and 18.8 mg. per cent total. Alkaline phosphatase stayed at the same high level of 30 sigma units.

On October 31, 1967, the patient was explored for obstructive jaundice. Exploration revealed the presence of a tumor occupying the entire length of the porta hepatis. The tumor's presence made access to the common bile duct impossible.

The Authors

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The liver was found to be very large and lobulated, but free of tumor. The most striking positive finding in this area was the presence of soft, whitish, vesicular-like structures on the surface of the liver (Figure 1). A biopsy specimen was taken from the portal area of the liver and sent for frozen section. One of the vesicular structures on the surface of the liver was opened, intubated with a soft polyethylene tube, and drainage of a clear fluid appeared. The pressure was measured and found to be 120 mm. of water. About three cc. of contrast media was injected through the polyethylene tube and x-ray was taken, but results were not conclusive. At this time the frozen section was interpreted as "doubtful adenocarcinoma." The procedure was terminated and the abdomen closed, bringing the polyethylene tube out through a separate stab wound.

Twenty-four hours postoperatively, the drainage tube drained clear fluid which progressed to yellow bile. The permanent section of the biopsy was reported as adenocarcinoma of the porta hepatis, and the patient underwent a second operation for palliation. A larger biliary duct was cannulated with a #12 Robinson tube. Intrahepatic biliary pressure was again measured and found to be 120 mm. of water. About 10 cc. of 50 per cent Hypaque was injected into this branch of the biliary duct and x-ray taken, revealing a very dilated, intrahepatic biliary system, showing the entire intrahepatic tributaries, including two main hepatic radicles (Figure 2). There was obstruction just after the junction and formation of the common hepatic duct. A Roux-en-Y intrahepatic cholangiojejunostomy (modified Longmire procedure) was performed. The peripheral bile canaliculi in this patient were so large that segmental hepatectomy was sufficient for identification of a large biliary duct to be used for anastomosis. Therefore, it was elected to resect a small segment of the left lobe of the liver. A fairly large dilated duct measuring 1.5 cm. in diameter was identified and this was used for hepatojejunostomy (Figure 3).

Postoperatively, bilirubin and alkaline phosphatase decreased gradually to a minimal level of direct bilirubin 1 mg. per cent, total 2.2 mg. per cent, and alkaline phosphatase of 4.5 sigma units (Figure 4). The patient was able to eat well and his pruritis subsided. Bilirubin and alkaline phosphatase stayed at this low level for a few weeks. The patient remained asymptomatic for approximately 10 weeks, but then a wound infection developed and a fistula appeared at the operative area. Pseudomonas septicemia added to the picture, and he became progressively worse and expired. Autopsy consent was not obtained.

Discussion

Complete high obstruction of the biliary tract due to carcinoma rarely is curable. The combination of complete biliary obstruction with

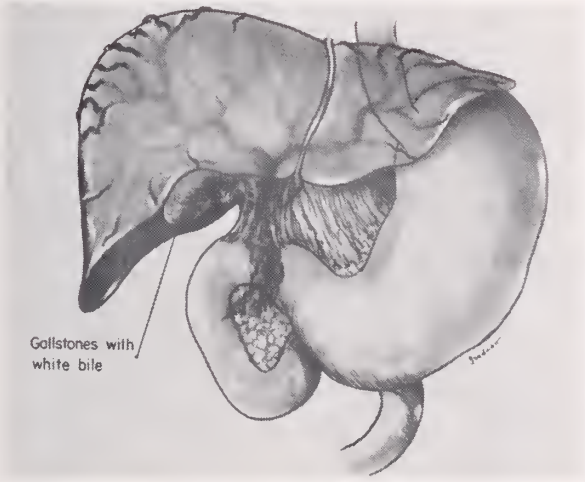

Figure 1: (1) Extremely dilated peripheral bile ducts on surface of liver; (2) large, dilated gallbladder filled with white bile; and (3) infiltrating carcinoma of porta hepatis obstructing common bile duct.

Figure 2: Operative cholangiogram through one of the peripheral bile duct branches, shows very dilated intrahepatic ductal biliary system.

secondary infection in these cases is responsible for early mortality, rather than the malignant disease itself.[4] Jaundice, itching, poor appetite and poor digestion also make this short life miserable. Neibling[5] reported the average survival period in cases of bile duct carcinoma as three to four months following operation. Palliative choledochoenterostomy usually is inapplicable in these cases due to extensive destruction and distortion of hepatic ducts. Decompression of the biliary tree through the liver hilus to the jejunum produces unsatisfactory results. The obstruction of the biliary-enteric anastomosis appears soon, due to progress of the tumor.[4]

Attempt at palliation for these victims was made by Sawyer,[6] in 1951, utilizing intrahepatic cholangiojejunostomy (Longmire procedure). His results, however, were not satisfactory. Utilizing the same technique, Waddell reported one case surviving for eight months, free of symptoms. Since then, additional cases achieving better results have been reported when this procedure was employed.

The picture of the case herein reported, however, is somewhat different from other cases that have appeared in the literature. Our patient had numerous, extremely dilated, biliary canaliculi on the liver surface, visible as large, white vesicles (Figure 1). The intubated biliary duct branch in the right lobe of the liver drained white bile, while the pressure measurement of the intrahepatic biliary system was only 120 mm. of water at operation, 100 mm. on the first postoperative day and 80 mm. on the second postoperative day. Biliary pressure of more than 200 mm. of water due to complete obstruction usually causes suppression of bile excretion and white bile appears.[7] White bile can be obtained, however, from biliary tract mucosa secretion when liver cells are damaged.[8]

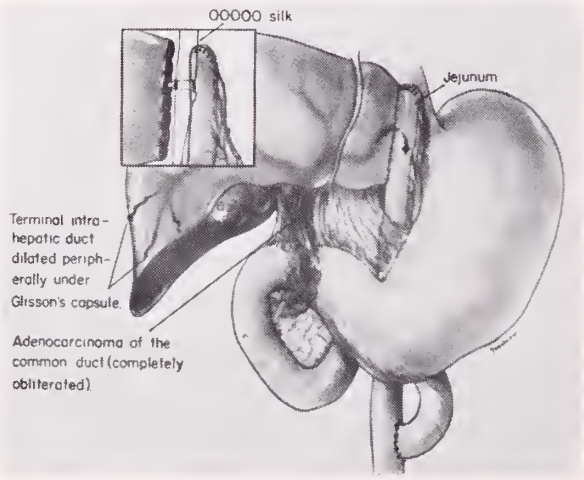

Figure 3: Partial left hepatectomy with hepatojejunostomy.

We believe, therefore, that the presence of white bile in this case was due to hepatic insufficiency or hepatic dysfunction from gradual complete obstruction in the biliary drainage. The reason for the absence of high biliary pressure, however, is not clear. One possibility is lack of biliary and hepatic resistance, as this complete obstruction stasis and backflow pressure resulted in extremely dilated canaliculi on the surface of the liver and in the intrahepatic branches, as revealed by intrahepatic cholangiogram (Figure 2).

The modified Longmire procedure was performed as a Roux-en-Y hepatojejunostomy. A segmental hepatectomy achieved a fairly large biliary duct measuring 1.5 cm. in diameter. This branch corresponded to the lateral segmental duct in the classification of Healey and Schroy.[9] The mucosa of the duct was anastomosed to the mucosa of the jejunum, using 5-0 interrupted silk sutures, and the seromuscular layer of the jejunum was attached to Glisson's capsule of the liver (Figure 3).

Postoperatively, the patient's jaundice subsided to almost normal level and his pruritis disappeared. Laboratory data pertinent to biliary tract patency are shown in Figure 4. The drop in alkaline phosphatase indicated drainage from both lobes of the liver. This was substantiated by the x-ray picture after radiopaque injection in the biliary system, revealing communication between the right and left hepatic radicles.

Summary

The anticipated short survival time of patients with intrahepatic and extrahepatic choledochal carcinoma is further decreased by biliary ob-

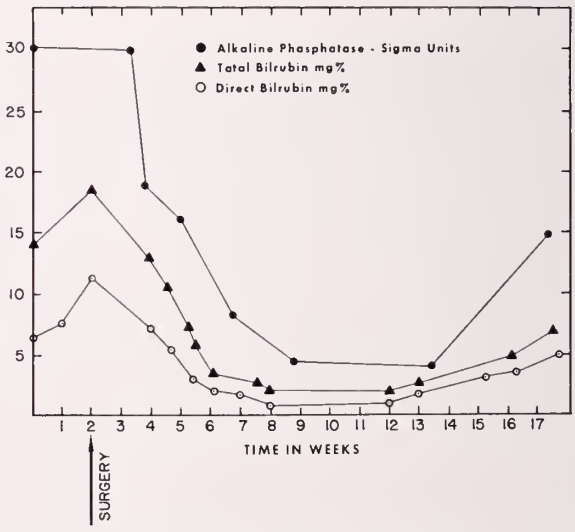

Figure 4: Preoperative and postoperative results of liver function tests. Note sharp decrease of values immediately following operation.

struction and infection. Prolongation of life in these cases has been achieved by palliative intrahepatic cholangiojejunostomy.

A case of adenocarcinoma of the common hepatic duct causing complete obstruction is reported. The peculiarity of this case regarding unusually dilated peripheral bile ducts on the surface of the liver and the method of diagnosis and approach is described. A modified hepatojejunostomy was performed for palliative purposes, and a satisfactory result is demonstrated by comparing the liver function tests before and after the procedure.

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Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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Electrocardiogram of the Month

Ventricular Parasystole

Edward K. Chung, M. D.

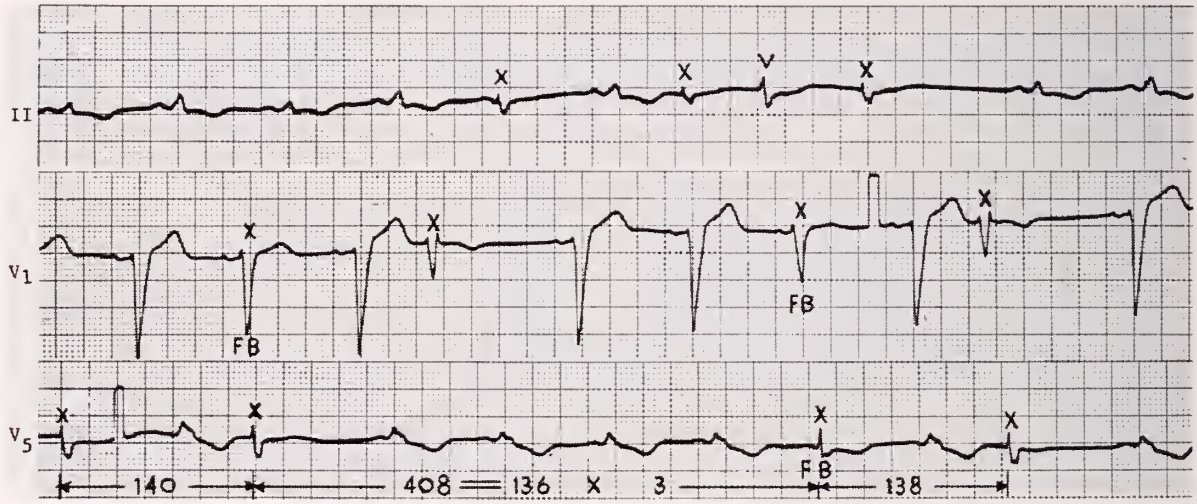
Parasystole consists of simultaneous activities of two (rarely more) independent impulse-forming centers, one of which is "protected" from the other, each competing to activate the atria or ventricles or both.[1-3] The parasystolic pacemaker may be located anywhere in the heart but is commonly located in the ventricles, less commonly in the A-V node and rarely in the atria.[1]

The Author

- **Edward K. Chung, M. D., Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratories, West Virginia University School of Medicine, Morgantown.**

The purpose of this paper is to present a case of ventricular parasystole and discuss the mechanism and the diagnostic criteria.

Electrocardiographic Analysis. Figure 1 was obtained from a 70-year-old female with a long-standing ischemic heart disease associated with left bundle branch block. In Figure 1, the basic mechanism is sinus and there are frequent ventricular ectopic beats (marked X). It should be noted that the coupling intervals (the interval from ectopic beat to preceding sinus beat) vary and the shortest interectopic intervals are relatively constant. The shortest interectopic intervals are between 1.36 and 1.40 seconds. It is interesting that there are frequent ventricular fusion beats (marked FB). The QRS complexes of the basic sinus beats are wide because of pre-existing left bundle block. In addition, one ventricular premature beat (marked V) is present in lead II. Sinus rate is 77 per minute and the parasystolic, 45.



Discussion. Parasystole as an electrocardiographic entity was first described by Kaufman and Rothberger in 1921.[4] The incidence of parasystole is about 0.12-0.15 per cent in general hospitals.[1-3] It is interesting to note that parasystole is twice as frequent in males as in females.[1] Various studies indicate that this arrhythmia is frequently encountered in elderly individuals, especially in those with diseased hearts.[1-3] The peak incidence is between the fifth and seventh decades.

In regard to the mechanism of parasystole, it is generally agreed that the parasystolic center, regardless of location, is protected by a unidirectional block from the transmission of impulses originating from any basic rhythm (protection block.) If a continuous protection block ensues,

the parasystolic pacemaker will act as the dominant pacemaker and produce a continuous parasystolic rhythm.[1] The exit block which is in the opposite direction of the protection block, prevents outward tranmission of the parasystolic impulses.[1] If there is an occasional exit block, the parasystolic beats appear intermittently while if the exit block is continuous the parasystolic rhythm will disappear.[1-3]

The diagnosis of parasystole[1-3] is made by proving the independence of the ectopic rhythm from the basic rhythm. The following diagnostic criteria are used: (1) Varying coupling intervals, (2) Constant shortest interectopic intervals and (3) Frequent appearance of fusion beats.

(1) *Varying Coupling Intervals:* The coupling intervals of ordinary premature beats (extrasystoles) are usually constant because the ectopic beats are dependent upon the basic rhythm. Parasystole should be suspected whenever coupling intervals show considerable variability (generally 0.06 second or more). Parasystolic beats may appear very early or late in the cycles of basic rhythm.

(2) *Constant Shortest Interectopic Intervals:* Constant interectopic intervals indicate that the ectopic focus produces impulses regularly and independently from the basic rhythm if the above mentioned criterion is present. The basic rhythm is almost always sinus, less commonly atrial fibrillation or flutter. If the interectopic intervals are long they should be a multiple of the shortest interectopic interval. However, occasionally, direct measurement of the parasystolic cycle is not possible. This is the case when only every other or third parasystolic beat appears on the electrocardiogram.

(3) *Fusion Beats:* If two impulses from different foci arrive more or less simultaneously in the heart, each impulse activates a part of the chamber involved, producing the appearance of an intermediate or mixed complex. Ventricular fusion beats are very common in ventricular parasystole especially when the rate of the basic rhythm is rapid as in sinus tachycardia, or irregular as in atrial fibrillation. Fusion beats have been called "combination or summation beats."

Summary

A case of ventricular parasystole is presented and the diagnostic criteria are discussed in detail. Parasystole should be suspected whenever following criteria are present: varying coupling intervals, constant shortest interectopic intervals and frequent appearance of fusion beats.

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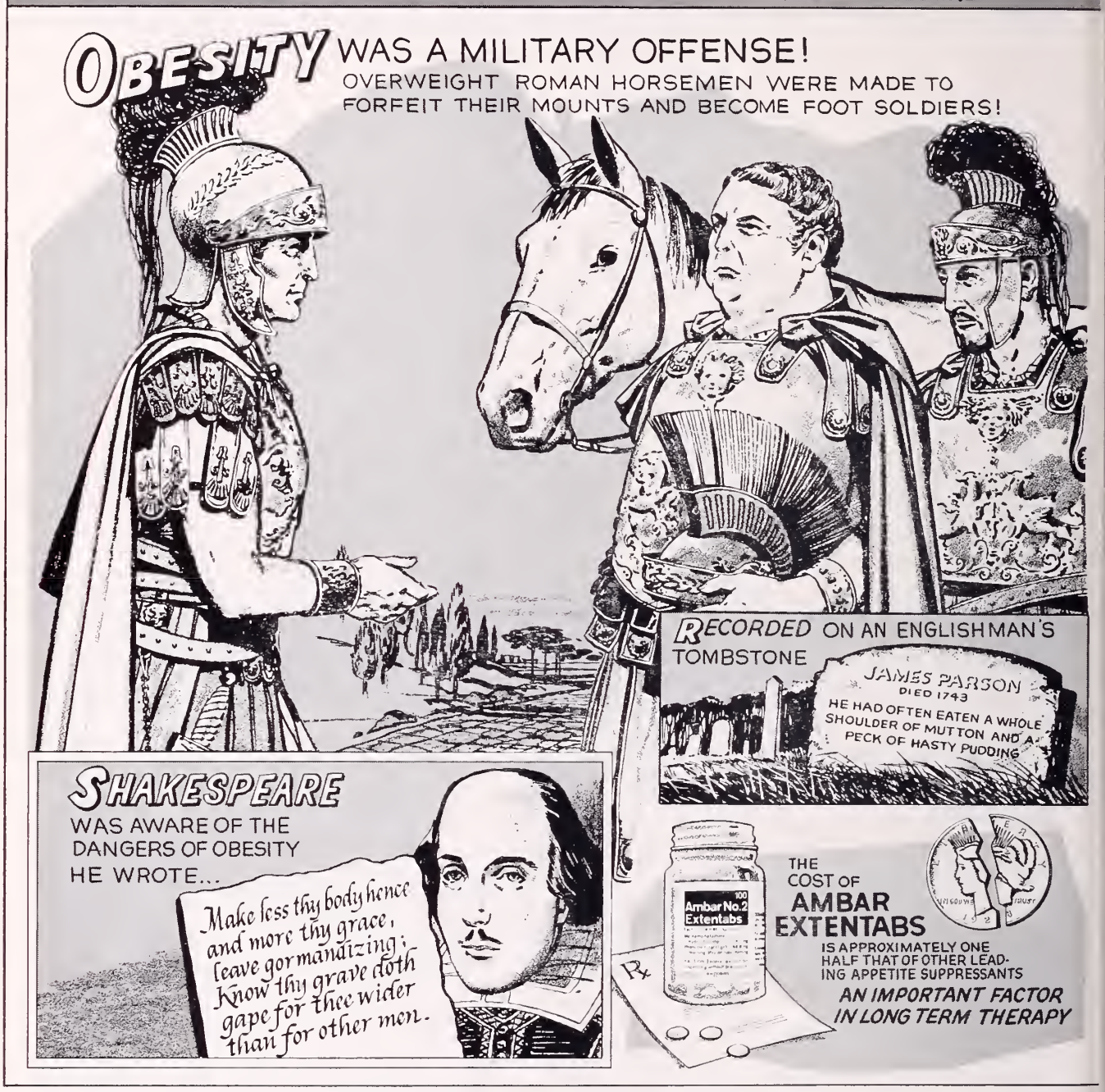

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Special Article

Rabies Prevention

Lauralee Sherwood, D. V. M.

Statistics show that rabies is a potential threat in West Virginia. During 1967, West Virginia ranked sixth in the nation in the incidence of canine rabies. During the first quarter of 1968, we ranked third and accounted for almost 14 per cent of the total cases of canine rabies in the United States. Wildlife rabies also is a big problem in our State. Foxes are the species most frequently reported with the disease. During 1967, West Virginia ranked seventh in the nation in the incidence of fox rabies. During the first quarter of 1968, we ranked ninth, and during the second quarter we ranked third.[1] Comparative statistics for the last half of 1968 have not yet been released from the National Communicable Disease Center. In addition to dogs and foxes, cases of rabies have been confirmed also in cats, horses, cattle, skunks and bats in our State. By the middle of March, 1969, West Virginia had reported a total of 32 confirmed cases of rabies in animals, compared with a total of 10 cases at this same date last year.[2] The distribution by county of the confirmed reported cases of animal rabies during the past year may be seen on the accompanying map.

The prevalence of rabies in West Virginia, combined with the fact that death is inevitable once the onset of symptoms occurs, justifies a discussion of the disease and its prevention.

Natural History of Rabies

All warm-blooded animals are susceptible to the neurotropic virus which causes rabies. The virus usually is transmitted via the bite of an infected animal or contamination of an existing wound with infective saliva. Aerosol transmission of rabies from bats also is possible.[3]

Once introduced, the virus travels centripetally over the neural pathways until it finally reaches the brain after a variable time. This period of time comprises the incubation period which is dependent on the site and severity of the bite. The relationship between the site of the bite and the incubation period appears to be governed by differences in the relative richness of peripheral innervation in various parts of the body rather than by the distance from the central nervous system.[4] The incubation period usually is shortest when the bite is around the head, face, and neck and, next, the extremities. The degree of trauma and extent of viral contamination also are important variables in determining the length of the incubation period. The range in man is 10 days to two years, one to three months average.[5]

The Author

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When the virus reaches the brain, the ensuing cellular damage causes the infected subject to manifest symptoms for the first time. During this period viral proliferation occurs. The virus then usually travels centrifugally from the CNS to the salivary glands via the peripheral nerves. Presence of the virus in the salivary gland makes possible the transmission of the disease to another animal or man under the impetus of the deranged mentality caused by the brain lesions.

Symptoms in Man

Clinical manifestations both in man and animals follow a generally similar pattern: Prodromal symptoms, followed by excitatory symptoms ("furious type") or paralytic symptoms ("dumb type") or both.

Prodromal: In man the most conspicuous prodromal symptoms are fever, headache, anorexia, nausea, malaise, sore throat, drowsiness, insomnia, irritability and restlessness. Paresthesia with a sensation of tingling, burning or pain around the site of the bite is a common occurrence early in the course of the disease.

Excitatory: Progessive excitatory symptoms generally ensue with increased anxiety, nervousness, excitability and hyperesthesia. Painful spasm of the muscles of deglutition occurs

upon swallowing, producing the symptom most commonly associated with human rabies—hydrophobia or "fear of water". There may be convulsive seizures and rarely maniacal symptoms and violence. The excitatory periods may alternate with relatively relaxed periods, during which the mind of the patient usually is clear. Most patients die during the height of an episode of excitation from peripheral vascular collapse.

Paralytic: In some the disease may progress to a generalized ascending paralysis, with or without the period of hyperexcitability, until the patient expires in prostration.

Symptoms in Animals

Generally the clinical picture in lower animals is similar to that in man, although some stages are more pronounced in different species and there is variability within species. Each stage presents a particular public health problem in so far as transmission to humans is concerned.

Prodromal: During the prodromal stage there frequently is a subtle change in temperament. A wild animal which normally could not be approached by humans frequently will allow a child to pick it up.

Excitatory: Of course another stage which is of public health concern is the excitatory or furious phase, during which time the animal will bite anything that is encountered, be it man, animal or inanimate object.

Paralytic: The paralytic or dumb form of rabies is dangerous for less obvious reasons. During this stage the animal has difficulty in swallowing because of pharyngeal paralysis. Consequently it appears to be choking, leading the owner to suspect an obstruction such as a bone in the throat. While attempting to remove the "bone" many pet owners needlessly expose themselves to the infective saliva.

Bats present a special public health problem in that vampire bats and probably insectivorous bats may be asymptomatic carriers. Furthermore, there is strong evidence of aerosol transmission in bat caves.[3]

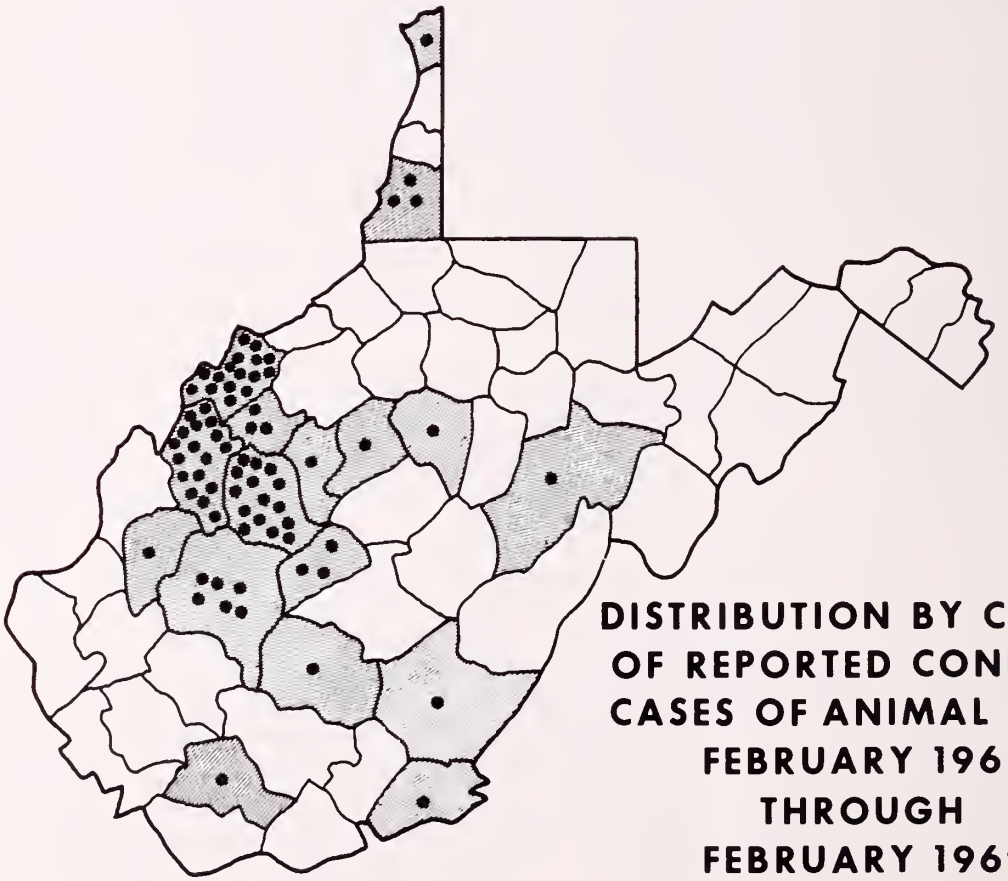
Rabies Prevention

There are two levels of rabies prevention. First, immediate action must be taken to prevent clinical rabies after a bite has already occurred and, second, long-range prophylaxis must be pursued to reduce the risk of exposure to rabies.

Immediate Action

A. *Treat the patient.*

1. Local wound treatment: The rationale here is to flush out or inactivate any rabies virus



DISTRIBUTION BY COUNTY OF REPORTED CONFIRMED CASES OF ANIMAL RABIES FEBRUARY 1968 THROUGH FEBRUARY 1969

which might have entered the wound. The following are procedures recommended by the World Health Organization Expert Committee on Rabies.[6]

a. First-aid treatment.

Wash and flush the wound immediately with soap and water, detergent, or water alone.

b. Treatment under medical supervision.

1. Adequate cleansing of the wound.

2. Thorough treatment with a 20 per cent soap solution or application of a quaternary ammonium compound or both. (All traces of soap must be removed prior to application of quaternary ammonium compounds because soap neutralizes the activity of such compounds).

3. Topical application of antirabies serum optional in cases of mild exposure, recommended for severe exposure; in severe exposure infiltration of anti-rabies serum around the wound also is recommended.

4. Tetanus prophylaxis and antibacterial therapy as indicated.

5. Suturing contraindicated.

II. Specific systemic treatment: Post-exposure vaccination.

The rationale here is an attempt to elicit an active antibody response to inhibit viral migration to the CNS. The question, however, of whether or not to administer post-exposure vaccination to persons inflicted with an animal bite or scratch involving possible exposure to rabies is a very perplexing one for several reasons.

First, promiscuous administration of antirabic inoculation should be discouraged because all available methods of systemic treatment occasionally have resulted in adverse reactions such as postvaccinal encephalitis and neurologic paralytic complications. Furthermore, the decision must be made quickly because the probability that immunization will be beneficial in preventing clinical rabies decreases as the interval between exposure and treatment increases. Therefore, sound judgment must be exercised in weighing each bite case on its individual particular circumstances. The Public Health Service Advisory Committee on Immunization Practices recommends that the following factors be considered before specific antirabies treatment is initiated:[7]

Species of biting animal involved: Carnivorous animals, especially skunks, foxes, coyotes, raccoons, dogs and cats) and bats are more likely to be infective than other animals. Bites of rodents seldom, if ever, require specific antirabies prophylaxis.

Circumstances of the biting incident: An unprovoked attack is more likely to mean that the animal is rabid. (Bites during attempts to feed or handle an apparently healthy animal should generally be regarded as provoked).

Extent and location of bite wound: The likelihood that rabies will result from a bite varies with its extent and location. For convenience in approaching management, two categories of exposure are widely accepted:

Severe: Multiple or deep puncture wounds, and any bites on the head, face, neck, hands, or fingers.

Mild: Scratches, lacerations, or single bites on areas of the body other than the head, face, neck, hands, or fingers. Open wounds, such as abrasions, which are suspected of being contaminated with saliva also belong in this category.

Vaccination status of the biting animal: An adult animal immunized properly with one or more doses of rabies vaccine has only a minimal chance of developing rabies and transmitting the virus.

Presence of rabies in the region: If adequate laboratory and field records indicate that there is no rabies infection in a domestic species within a given region, local health officials may be justified in taking this into consideration in any recommendations concerning antirabies treatment following a bite by that species.

Frequently the local veterinarian can be of assistance in supplying some of the preceding information.

Once the decision is reached to initiate specific systemic treatment, a choice of preparations is available.

(a) *Nervous tissue vaccine*—prepared from rabbit CNS tissue infected with a fixed virus and inactivated by phenol at 37°C (Semple type) or inactivated by ultraviolet radiation.

(b) *Duck embryo vaccine*—prepared from embryonated duck eggs infected with a fixed virus and inactivated with betapropriolactone.

Since rates of treatment failures with the two vaccines are not significantly different, The Public Health Service Advisory Committee on Immunization Practices recommends the use of duck embryo vaccine rather than nervous tissue vaccine because of a lower frequency of CNS reactions associated with the avian vaccine.[7]

(c) *Hyperimmune antirabies serum*—used in conjunction with vaccine is considered to be the best post-exposure prophylaxis. The WHO Expert Committee on Rabies recommends its use in all severe exposures and in all cases of unprovoked wild animal bites. As with vaccine alone, it is important to start combined serum and vaccine treatment as early as possible after exposure, but serum should still be used when indicated regardless of the time interval. The dose recommend is 40IU per kg. of body weight given in a single dose simultaneously with the first dose of vaccine. Appropriate tests to determine hypersensitivity to the serum must be performed prior to its administration.[6]

Schedule of Vaccine Use: A daily subcutaneous injection of the vaccine should be administered for at least 14 days; in severe exposure the immunization regimen should be extended to 21 days. Recommended vaccination sites are the abdomen, lower back, or lateral aspect of the thighs.

Booster doses should be given at 10 days and at 20 or more days following the primary course of vaccination in all cases. This is particularly important if antirabies serum was used in the initial therapy in order to overcome any possible interference phenomena.[7]

Guide for specific post-exposure treatment: While taking into consideration all factors in-

SPECIFIC SYSTEMIC TREATMENT

Nature of exposure	*Status of Biting Animal (Irrespective of Whether Vaccinated or Not)* — *At time of exposure*	*During observation period of ten days*	*Recommended treatment*
I. No lesions; indirect contact	Rabid	---	None
II. Licks:			
1. Unabraded skin	Rabid	---	None
2. Abraded skin, scratches and unabraded or abraded mucosa	(a) Healthy	Clinical signs of rabies or proven rabid (laboratory)	Start vaccine at first signs of rabies in the biting animal.
	(b) Signs suggestive of rabies	Healthy	Start vaccine immediately; stop treatment if animal is normal on fifth day after exposure.
	(c) Rabid, escaped, killed or unknown	---	Start vaccine immediately.
III. Bites:			
1. Mild exposure	(a) Healthy	Clinical signs of rabies or proven rabid (laboratory)	Start vaccine at first signs of rabies in the biting animal.
	(b) Signs suggestive of rabies	Healthy	Start vaccine immediately; stop treatment if animal is normal on fifth day after exposure.
	(c) Rabid, escaped, killed or unknown	---	Start vaccine immediately.
	(d) Wild (wolf, jackal, fox, bat, etc.)	---	Serum immediately, followed by a course of vaccine.
2. Severe exposure (multiple, or face, head, finger or neck bites)	(a) Healthy	Clinical signs of rabies or proven rabid (laboratory)	Serum immediately; start vaccine at first sign of rabies in the biting animal.
	(b) Signs suggestive of rabies	Healthy	Serum immediately, followed by vaccine; vaccine may be stopped if animal is normal on fifth day after exposure.
	(c) Rabid, escaped, killed or unknown (d) Wild (wolf, jackal, pariah dog, fox, bat, etc.	---	Serum immediately, followed by vaccine.

volved in each individual case, recommendations prepared by the WHO Expert Committee on Rabies (Page 222) may be used as a guide for specific systemic treatment. It is intended only as a guide and recommended procedures should be modified when indicated.[6]

B. *Confine the animal.* While appropriate treatment is being initiated, other immediate action should be taken. The biting animal should be captured, confined, and observed for at least 10 days, preferably under veterinary supervision. If the animal were secreting infective saliva at the time of the bite, it should develop clinical symptoms of rabies within 10 days. If the animal dies, positive diagnosis of rabies can be made by appropriate laboratory examinations of the brain. The head should be promptly cooled, placed in a watertight container surrounded by cracked ice, and submitted to the county health officer.

C. *Apprehend other animals bitten by the suspect animal.* If the suspect animal is proven rabid, all unvaccinated exposed animals should be destroyed or confined for observation for at least six months. All vaccinated animals bitten by a rabid animal should be revaccinated and confined for 30 days.

D. *Report the biting incident to the state health department.*

Long Range Control

The ultimate goal in rabies prevention is, of cause, elimination of the disease. Unfortunately, this is impossible at present because of the complex epidemiological patterns of the disease. Rabies, however, can be controlled even if it cannot be eliminated, thus reducing the risk of exposure.

Sylvatic rabies is the primary reservoir for the disease. Rabies, however, can spill over into urban animal populations, becoming enzootic or epizootic. Factors which influence the presence of rabies both in wild and domestic animals simultaneously in a given area are the degree of contact between the two groups, the relative population size of both groups, and the immunity status of the urban population. Stray dogs are a major factor in dissemination of the disease since they are not immunized and are free to roam among both wild and pet animals. Therefore, all of these factors must be taken into consideration to achieve adequate rabies control.

A. *Preventive measures aimed at the pet population.*

1. Pre-exposure vaccination programs.

Immunization of at least 80 per cent of the dog population over a large area, when maintained continuously for a period of years, creates an immune barrier so high that the disease cannot be sustained. It also reduces the potential danger of the carrier stray dog. In fact, in West Virginia, it is required by law that all pet dogs be vaccinated against rabies every two years.

Rabies does not usually continue to propagate in other domestic species when the disease is eliminated in the canine and wildlife populations. When, however, rabies persists in the latter groups it is advisable also to vaccinate other pet species, particularly cats.

2. Strictly enforced licensing and leashing laws.

These measures reduce contact between pets and their stray and wild counterparts, and also facilitate stray dog control.

B. *Stray dog control.*

Elimination of stray dogs through local pounds or animal shelters remains the best control measure aimed at this group of animals.

C. *Selective wildlife control.*

The wildlife reservoir presents a difficult problem in rabies control. Since wild animals cannot feasibly be immunized, programs for population reduction of proven vector species continue to be the only method available. Selective destruction through organized trapping and poisoning programs is used to thin out the particular vector species to the point where the possibility of animal-to-animal contact is minimal.

D. *Pre-exposure prophylaxis for high-risk groups.*

Pre-exposure rabies prophylaxis is advisable for high-risk groups such as veterinarians, dog catchers, wildlife conservationists, and persons traveling to countries where rabies is epizootic. Either duck embryo vaccine or high egg passed chicken embryo vaccine may be used. The duck embryo vaccine, however, appears to be more immunogenic. Two 1 ml. injections of duck embryo vaccine are given subcutaneously in the deltoid area one month apart, followed by a third dose seven months later.[8] One month after the third dose neutralizing antibodies may be detected in 80 to 90 per cent of cases. If no antibody titer is demonstrable, booster doses should be given until a response is elicited. One ml. boosters should be administered every two to three years so long as the individual remains at risk.

If a bite should occur when a titer has been demonstrated in the past, one booster dose of vaccine is considered sufficient for a mild exposure; for a severe exposure, five daily doses of vaccine plus a booster dose 20 days later is recommended.[7]

E. *Public awareness.*

The best control measure aimed at the general population is public education. Without public cooperation the other prophylactic measures will not be expedited. The public should be aware that their pets should be vaccinated and properly restrained, that the police should be notified of stray dogs, and that wild animals should not be approached, particularly if acting strangely.

As a key member of the public health education team, every physician should therefore realize that his role in rabies prevention extends far beyond the immediate treatment of a bite wound. He must promote and support a strong, well organized, well publicized rabies control program, as outlined above, in his community.

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To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal will* receive individual and immediate attention.

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A message from . . .

The President

MUTUAL PROBLEMS

YOUR President has been traveling quite extensively recently. In April we attended the Maryland State Medical Association meeting in Baltimore and in May, the Ohio State Medical Association meeting in Columbus. Both of these meetings were very well attended. I might say that nearly all the problems that they discussed were also problems that we have. One of the most pressing ones in most states, especially in Maryland, had to do with Workmen's Compensation. Nearly all the physicians in West Virginia know we have not been very happy with the past Compensation procedures. I can report that a conference has been held with the new State Workmen's Compensation Commissioner, Mr. Fred Davis, Jr., and we are making progress which I believe will be to the satisfaction of all concerned. Mr. Davis has been very cooperative with our representatives in all phases.

On May 16-18 I attended the AMPAC meeting in Washington during which many interesting discussions were held. Our own Senior Senator, Jennings Randolph, was one of the featured speakers and gave a very enlightening talk which was well received. He spoke on air and water pollution and coal mining problems. He also stressed the importance and necessity of hearing from the public while bills are in committee rather than on the floor for the vote.

Again, I want to remind our physicians that we have a member of our Association running for one of the highest offices in the AMA. He is Carl Hoffman, a candidate for Vice Speaker of the House of Delegates of the AMA. Many of us have been doing everything we can to elect Carl to this office. For those physicians who are attending the AMA meeting in New York in July, the West Virginia State Medical Association will have a suite in the Americana which will be open at designated hours for all West Virginia physicians and we certainly hope you will come by because it is your suite.

Richard W. Corbitt, M.D.

RICHARD W. CORBITT, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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EDITORIALS

PLANTING THE SEED

It has turned out to be a far cry from my college days to the current long hair vogue and the revolt on the campuses with armed confrontation and now loss of life. The long hair I can live with; the campus revolts are not my cup of tea. Just recently it suddenly dawned on me that gradually but definitely I had been making an attempt, puny, but none the less, a personal effort to try to remedy the situation.

Each year I have been examining high school seniors after they have been accepted for college. Every college or university has its own form for physical evaluation of each freshman that has to be filled out by a physician. Most of these freshmen-to-be, boys, girls, black, white, have known me for several years, some for their entire lifetimes. The examination of these 17 and 18-year-old youngsters is one of the first big steps in the beginning of an exciting new career, whether the teen-ager lives at home or away.

They are definitely out of the sheltered pediatric stage, about to enter an entirely new environment, college, in which they must make their own decisions and meet the great unknown largely by themselves. At any convenient point in the examination, when I feel we have rapport, I try casually to emphasize three things to the student. Call it advice, call it preaching - - - some listen but don't hear. Many listen and do hear.

(1) I point out to the youngster the absolute necessity for studying intensively the first few months to get off to a good start in college.

(2) I tell him to stay away from drugs, no matter how desirable and innocuous the temptation might seem. My argument is that in my opinion it will be eight to ten years yet before the campus drug problem will be resolved, that by then the as yet unborn offspring of parents who are taking pot and LSD now probably will show congenital deformities compatible with the chromosomal breaks just now being demonstrated in addicts.

(3) Finally, I don't advise; I offer a choice. He can have law and order with evolution. Or he can have anarchy with revolution. We have been seeing a lot of anarchy on the campuses, with complete defiance of those legal and moral standards which a Revolution won and which a War between the States could not dissolve. The Revolution of 1776 had its goal; the campus revolution of 1969, by the very words of its own leadership is out to destroy.

I tell him that if he feels changes are necessary, he has to make up his own mind the best way to achieve those changes, and push his efforts accordingly. I emphasize that the choice is his, not mine, not his parents', not his teachers'.

Were every physician in this country to make an effort, just to take five minutes, to offer such a choice to every new college student he examines, in my opinion 95 per cent of each new freshman class would be reached before they reach the campuses. For an impressionable teenager to be talked to as an adult by somebody he respects could plant the seed of rational thinking and might reap a welcome harvest. For the medical profession not to do so would not only be the loss of a golden opportunity available only to us, but be a disservice to our country.—*Guest Editorial by Leonard M. Eckmann, M. D., South Charleston.*

THE CONTROL OF RABIES

Elsewhere in this issue of *The Journal* may be found an article dealing with rabies prevention and the incidence of rabies among animals in West Virginia during the year 1968. Rabies has been endemic in the State for many years. In the first quarter of 1968 West Virginia ranked third, and accounted for almost 14 per cent of the total cases of canine rabies in the United States. Rabies in wildlife in West Virginia also presents a serious problem. Foxes are the most common animals afflicted with the disease; for example, in 1967 West Virginia ranked seventh in the nation in the number of fox rabies, and in the second quarter of 1968 ranked third in the nation. These observations are most disheartening. It is indeed surprising that more human deaths have not been reported.

Carnivorous animals, such as foxes, skunks, raccoons, dogs and cats, are more likely to be infective than are other animals. Bats, also, may spread the disease. Because of the complex epidemiological pattern of the disease it is difficult to eradicate rabies. Its spread, however, can be controlled. A heartening factor is that the risks of exposure can be greatly reduced if all dogs in the State are immunized to rabies. There appears to be evidence that if at least 80 per cent of the dog population be immunized to rabies, and if this percentage of immunization of animals is maintained for a period of years, an immune barrier is created so high that the disease cannot be sustained. It would seem that this practice could be carried out in the State, as there is a law in West Virginia that all dogs must be vaccinated to rabies every two years. This law should be strictly enforced.

The article stresses the fact that wildlife reservoirs in the State create a difficult problem indeed. About the only method to control this situation is to initiate a trapping or a poisoning program to lessen the animals which are most likely to spread the disease. In West Virginia this would be the fox. The wanton destruction of wildlife is viewed with alarm by many substantial citizens and rightly so. The fox, for example, distinctly adds to the charm of the State. It must be remembered, however, that treatment following exposure to rabies may be an unpleasant and expensive experience; serious complications may occur and, unfortunately, the development of rabies cannot always be checked even with the use of the latest and best possible therapeutic methods of immunization. In essence, all physicians should be aware of the seriousness of the problem in the State, and should encourage the enforcement of laws which help control the spread of rabies.

Facts for the 'Fickle Finger'

"Laugh-In" is an hilarious TV program, high in the popularity polls and dedicated to noisy comedy and inconsequential persiflage.

"The Fickle Finger of Fate Award" is a feature of the show which depends not on comedy but on satire and ridicule for its entertaining effect. And this is not bad usually, especially when the satire is based on fact.

Recently an attempt was made to assign the "Fickle Finger of Fate Award" to the pharmaceutical industry. Departure from the facts, however, spoiled the effect. The whole procedure resembled a smear campaign.

It was stated that the pharmaceutical industry spends $600 million annually on advertising and that this explains why drugs are so expensive. A second departure from facts stated that the industry spends only one-fourth as much on research as it does on advertising.

As a matter of fact, if the annual financial statements of all pharmaceutical manufacturers were consolidated, there would be a $600 million item in the tally, but not for advertising. This is the annual amount which the entire industry spends for all promotional and distributional expenses. Advertising is a small fraction of this total.

Fact No. 2 is that research does not cost $150 million, as implied by "Laugh-In," but adds up to $520 million per year. The drug industry spends, relatively, more on research than any other industry in the U. S.

The pharmactutical industry is also unusual in the fact that it accepts the least amount of government research money. In 1968 only 2.4 per cent of the $520 million was obtained from the government. Several industries obtain over half of their research money from government.

"Laugh-In" was wrong in implying that drugs are increasingly expensive. Since 1957 prescription drugs have decreased in price by some 12 per cent while the Consumers Price Index has been increasing by around 22 per cent. Drugs are only one of a few items that are actually less expensive now than they were 10 years ago.

Too bad to ruin a good show with such inaccurate reporting.—*The Journal of the Indiana State Medical Association.*

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 21-23

The scientific program has been completed for the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.

Francis M. Forster, M. D.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that nine prominent out-of-state physicians and surgeons will be the speakers at the three general scientific sessions on Thursday, Friday and Saturday mornings, August 21-23. The session on Saturday morning will be devoted to a Symposium on "Cardio-Respiratory Emergencies and Their Management." The Moderator will be Dr. Herbert E. Warden, Professor of Surgery at the West Virginia University School of Medicine.

Francis M. Forster, M. D.

Dr. Francis M. Forster, Professor and Chairman of the Department of Neurology at the University of Wisconsin Medical Center, will appear as a speaker at the first general scientific session on Thursday morning, August 21.

A native of Cincinnati, Doctor Forster received his M. D. degree in 1937 from the University of Cincinnati School of Medicine. He interned at Good Samaritan Hospital in Cincinnati and served as a House Officer in Neurology and Neurosurgery at Boston City Hospital. He served as a Fellow in Psychiatry at Pennsylvania Hospital and served a residency in neurology at Boston City Hospital.

He served one year as Assistant in Neurology at the Harvard Medical School and a year as Rockefeller Foundation Research Fellow in Physiology at Yale University School of Medicine. He served on the faculties of Boston University School of Medicine and Jefferson Medical College and was appointed in 1950 as Professor of Neurology and Director of the Department at Georgetown University School of Medicine.

In 1953 he was appointed Dean of the Georgetown University School of Medicine. Since 1958 he has been serving as Professor and Chairman of the Department of Neurology at the University of Wisconsin Medical Center.

First General Scientific Session

The speakers at the first general scientific session on Thursday morning will be as follows:

Maj. Gen. Joe M. Blumberg (MC), Commanding General, U. S. Army Medical Research and Development Command, Washington, D. C. Subject: "Some Interesting or Unusual Cases in Forensic Pathology."

Albert B. Ferguson, Jr., M. D., Professor and Chairman of the Department of Orthopedic Surgery, University of Pittsburgh School of Medicine. Subject: "Degenerative Arthritis of the Hip—What It Is and the Modern Methods of Taking Care of It."

Francis M. Forster, M. D., Professor and Chairman of the Department of Neurology, University of Wisconsin Medical Center. "Subject: "Behavioral Treatment of Epilepsy—1969."

Second General Scientific Session

The speakers at the second general scientific session on Friday morning will be as follows:

Kermit E. Krantz, M. D., Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center. Subject: "The Placenta—Man's Best Friend."

Raymond J. Jackman, M. D., Head of the Section of Proctology, The Mayo Clinic, Rochester, Minnesota. Subject: "Crohn's Disease."

Felix de la Cruz, M. D., Chief, Children's Diagnostic and Study Branch, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland. Subject: "Physicians' Role in Mental Retardation."

Third General Scientific Session

The third general scientific session on Saturday morning will be devoted to a Symposium on "Cardio-Respiratory Emergencies and Their Management."

Dr. Herbert E. Warden, Professor of Surgery at the West Virginia University School of Medicine, will serve as Moderator and the other participants will be as follows:

E. M. Papper, M. D., Professor and Chairman, Department of Anesthesiology, College of Physicians and Surgeons of Columbia University, New York City.

Bruce C. Sinclair-Smith, M. D., Associate Professor of Medicine, Vanderbilt University School of Medicine, Nashville, Tennessee.

W. Glenn Young, Jr., M. D., Professor of Surgery, Duke University School of Medicine, Durham, North Carolina.

Time will be allotted for questions and answers following the presentation of each paper.

Afternoon Meetings

Meetings of all sections and affiliated societies will be held on Thursday and Friday afternoons. All of the guest speakers have accepted invitations to present papers at the afternoon meetings and their subjects will be announced in the August issue of *The Journal.*

Gov. Moore and Dr. Dorman Honor Guests

The Hon. Arch A. Moore, Jr., Governor of the State of West Virginia, will deliver an address at the opening of the first general scientific session on Thursday morning, August 21.

Dr. Gerald D. Dorman of New York City, who will be installed this month as President of the American Medical Association, will speak at the first session of the House of Delegates on Wednesday afternoon, August 20.

Members of the Auxiliary and other guests attending the meeting at The Greenbrier are cordially invited to listen to the addresses by Governor Moore and Doctor Dorman.

Business Sessions

The pre-convention meeting of the Council will be held on Wednesday morning, August 20. The first session of the House of Delegates will be held that afternoon.

Dr. Richard W. Corbitt of Parkersburg, the President, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 23. Officers for the coming year also will be installed at that time.

Entertainment Features

The entertainment program for the Annual Meeting is under the direction of the Woman's Auxiliary. There will be a dance on Friday night in Chesapeake Hall and a reception honoring officers of the State Medical Association will be held on Saturday evening.

Room Reservations Pass 500 Mark

The number of room reservations at The Greenbrier for the Annual Meeting in August has passed the 500 mark and it is anticipated that more than 700 persons, including physicians, their wives and guests will be in attendance. All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the Annual Meeting will be published in the August issue of *The Journal.*

Dr. Barnes Is Pediatric Fellow

Dr. Felino V. Barnes of Ronceverte was elected an Affiliate Fellow of the American Academy of Pediatrics during the Academy's Annual Meeting in Boston in April.

ACP Elects Doctor Davis

Dr. Preston C. Davis of Beckley was recently elected to membership in the American College of Physicians.

West Virginia Hospitality Suite In New York City

West Virginia physicians and their wives are cordially invited to visit the hospitality suite of the West Virginia State Medical Association during the Annual Convention of the American Medical Association in New York City in July.

The suite will be in the Americana Hotel, and the room number will be posted on the bulletin board in the lobby. The suite will be open from 5 to 7 P.M. on Sunday, Monday and Tuesday evenings, July 13-15.

If you plan to attend the AMA Convention, make it a point to drop by the West Virginia Suite.

College of Legal Medicine Meets in New York

The Annual Meeting of the American College of Legal Medicine will be held at the Warwick Hotel in New York City on Sunday, July 13.

Theme for the session will be "The Physician and the Law," and the Moderator will be Monroe E. Trout, M. D., LL. B.

Speakers will include: Albert Averbach, LL. B., Trial Lawyer, Author and Lecturer; Herbert L. Ley, Jr., M. D., Commissioner of the Food and Drug Administration; Charles J. Frankel, M. D., LL. B., Professor of Law and Orthopedics at the University of Virginia; and Milton Helpern, M. D., Medical Examiner, New York City.

Dr. J. Mark Hiebert, Chairman of the Board of the Sterling Drug Company, will be speaker for the Annual Banquet.

Teaching Hospitals Council Adopts Constitution

The second organizational meeting of the West Virginia State Medical and Hospital Associations' Joint Council on Teaching Hospitals was held in Charleston on May 22, with the Chairman Pro Tempore, Dr. David Z. Morgan of Morgantown, presiding.

Approximately 25 members attended the session, during which a Constitution and By-Laws were adopted. Election of officers will be conducted at the next meeting, which probably will be held sometime this summer. In the meantime, Doctor Morgan will continue as temporary Chairman.

Membership is open to those West Virginia hospitals which operate or are affiliated with one or more approved graduate training medical education programs. Each hospital is entitled to three seats on the Council, including the Administrator, one member of the medical staff and one member of the governing board.

The West Virginia State Medical Association and the West Virginia Hospital Association have three representatives each, while the West Virginia University School of Medicine has one.

Pulmonary Disease Course In Cleveland

The annual Cleveland Course in Pulmonary Disease will be conducted at St. Luke's Hospital in Cleveland, September 24-26.

The title of this year's session is "The Clinical Application of Pulmonary Physiology." It is aimed at updating internists, pediatricians and thoracic surgeons in the principles of pulmonary physiology that would be helpful in the diagnosis and management of pulmonary diseases.

Sponsors of the course are the Case Western Reserve University School of Medicine; the Tuberculosis and Respiratory Disease Association of Cleveland and Cuyahoga County; the Ohio Tuberculosis and Health Association; and the American Thoracic Society.

Included in the three-day course are lectures, demonstrations, case presentations, and audience participation in clinical discussion.

Registration fees include $75 for members of the American Thoracic Society and $100 for nonmembers.

Additional information may be obtained by writing to: Dr. Wallace J. Mulligan, Office of Postgraduate Medical Education, School of Medicine, Case Western Reserve University, 2107 Adelbert Road, Cleveland, Ohio 44106.

Dr. Theodore G. Klumpp Is Fund President

Dr. Theodore G. Klumpp, President of Winthrop Laboratories, has been elected President of the National Fund for Medical Education.

The Fund is an organization concerned with the financial problems of medical schools. Doctor Klumpp has been a Director of the Fund for many years.

Journal Advertising Salesman Is Honored

Mr. Monte Brown of Chicago, who sells advertising contracts for *The West Virginia Medical Journal* and other medical publications, was honored by his colleagues recently.

Mr. Brown, who is associated with Medical Media Associates, Inc., was given the second annual "Space Representative of the Year" award by Sieber and McIntyre, sponsors of the event. The award consists of a plaque and $500.

The award honored Mr. Brown as the space representative who best serves the industry through creative selling and a thorough understanding of the advertisers' products and problems.

Mr. Brown and his partners represent the State Medical Journal Advertising Bureau, which includes of *The West Virginia Medical Journal* and 33 other state medical journals.

Arthritis Foundation Publishes Manual for Patients

A 24-page illustrated booklet entitled "Home Care Programs in Arthritis—A Manual for Patients" has been published by The Arthritis Foundation.

Prepared by the Allied Health Professions Section of the Foundation, the booklet will be offered by local chapters of the Foundation at no cost to physicians who may in turn distribute them to their patients.

The booklet is written in language the layman can understand. It combines common sense advice to the arthritis patient on various situations which affect him.

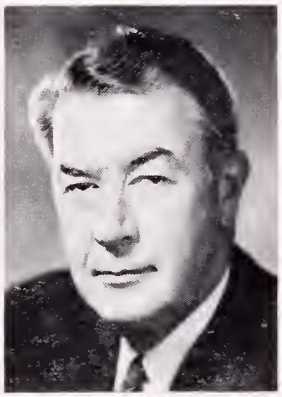
Copies may be obtained by physicians from local chapters of The Arthritis Foundation or from the national headquarters at 1212 Avenue of the Americas, New York, New York 10036.

Looking Back 10 Years . . .

This picture was taken during the Rural Health Conference of 1959. This panel which discussed "Rural Dental Needs" consisted of (left to right): Dr. Kenneth V. Randolph of Morgantown, who in 1968 resigned as Dean of the West Virginia School of Dentistry to accept a similar position elsewhere; Dr. Raymond J. Vassar of Weston; Dr. Gerald R. Guine of Charleston; and Miss Madge Lee Duncan of Clarksburg.

Marshall Alumni Honor Doctor Hoffman

The Marshall University Alumni Association has presented its Distinguished Alumnus Award to Dr. C. A. (Carl) Hoffman of Huntington.



C. A. Hoffman, M. D.

The award is presented each year to one or more Marshall alumni in recognition of achievement in their career fields.

A native of Ironton, Ohio, Doctor Hoffman has a urological practice in Huntington.

For many years Doctor Hoffman has been active in civic and professional activities. He is a Past President of the West Virginia State Medical Association and the American Urological Association.

At the present, Doctor Hoffman is a member of the House of Delegates of the American Medical Association and the Medical Licensing Board of West Virginia and also serves as Secretary of the Board of Directors of the National Association of Blue Shield Plans.

The award was presented to Doctor Hoffman at the 32nd Annual Alumni Day Banquet.

S. S. HOPE Will Make Tunisian Voyage

The S. S. HOPE will sail for Tunisia late in August for a 10-month stay, making her first return to the African continent since a voyage to Guinea five years ago.

Announcement of this summer's voyage was made by Dr. William B. Walsh, Founder, President and Medical Director of Project HOPE; and Richard Driss, the Tunisian Ambassador to the United States.

"Project HOPE will mark its tenth anniversary during our stay in Tunisia, and I anticipate that this will be one of the HOPE'S most productive and noteworthy programs," Doctor Walsh said.

He said that, based on initial survey reports, the HOPE medical staff will be placing great emphasis on working with Tunisian medical students, interns and residents. Educational exchange programs will be conducted in medicine, dentistry, nursing, public health, medical technology, pharmacy and other paramedical specialties.

The medical mission to Tunisia will be the ninth voyage the S. S. HOPE has taken since her maiden voyage in 1960. Since then, the ship's facilities and programs have touched the lives of more than two million people on four continents.

A tentative sailing date of August 31 has been set, with the S. S. HOPE departing Philadelphia.

Regional Medical Program Opens Field Office

The West Virginia Regional Medical Program has chosen Parkersburg as the location of its first subregional office. The decision was made at a meeting of the RMP Advisory Committee.

The Parkersburg office will be headed by a coordinator to be named in the near future.

Under plans developed for West Virginia, RMP activities are to be decentralized on the basis of nine sub-regions of the State established by the West Virginia Department of Commerce. The planning budget includes funds for employment of one area coordinator this year. The others are to be phased in over a three-year period.

Primarily the area coordinators will be reasonsible for the development of community-based, university-related programs for continuing education and training for health professions. They also will be responsible for public education in health matters.

Dr. Alfred Soffer Is Named Director of ACCP

Dr. Alfred Soffer has been named Executive Director of the American College of Chest Physicians, effective July 15.

He succeeds Mr. Murray Kornfeld, who has held the post since the founding of the College in 1935. Mr. Kornfeld will assume new duties as Executive Trustee and Consultant to the Executive Director and Board of Regents.

A fellow of the College since 1960, the new Executive Director is Editor-in-Chief of *Diseases of the Chest*. He has held that post for the past year and has been Director of Scientific Activities for the College since November of 1967.

Doctor Soffer received his M. D. degree at the University of Wisconsin. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Cardiology.

Another $500 Contribution To Scholarship Fund

The Medical Arts Supply Company of Huntington has made a contribution of $500 to the Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association. This is the eleventh consecutive year that the Company has contributed the sum of $500 to the Scholarship Fund.

Under the program, 18 students already have been awarded scholarships of $4,000 each to the West Virginia University School of Medicine.

Health Department Pioneers In Planning Field

In the last few years increasing emphasis has been placed upon the development of master plans for civic improvement in social and economic areas such as urban development, pollution abatement, assistance to the underprivileged and health services. The State Department of Health has been a pioneer in the planning field.

Dr. N. H. Dyer, State Director of Health, reported in a recent issue of the "State of the State's Health" that the State Plan for Hospital and Medical Facilities Construction originated some 20 years ago and through annual revisions, continues to be the primary document for guiding and influencing the development of patient care services through the construction and modernization of hospitals and related medical facilities throughout the State.

In 1965 and 1966, the State Department of Health originated two new plans, the West Virginia State Plan for Mental Retardation Facilities Construction Program and the West Virginia State Plan for Construction of Community Mental Health Centers. As their predecessor, the two newcomers are public documents for guiding and influencing the development of mental retardation services through the construction of needed public and non-profit facilities for the mentally retarded and to present a coordinated comprehensive program for the orderly development of needed community mental health facilities and services where appropriate.

Advisory councils were created to meet the responsibility of developing and maintaining the documents. Basically, the responsibilities of the councils are to develop and follow a policy of cooperative endeavors. Their specific role is to offer advice and suggestions that will assist in the administration of the plans. The council members were selected and appointed by the Governor from recommendations submitted by various state agencies and other interested groups.

In planning for hospitals and medical facilities, it has become increasingly apparent that to provide comprehensive health services economically, duplication of services may be avoided by locating and incorporating other health facilities in conjunction with general hospitals. The concept of the general hospital as the focal point of comprehensive health services is recognized and encouraged.

The guidelines for the development of the plans are very similiar in context with a few exceptions that are peculiar to the particular category. In 1965 and 1966, the application of the Appalachian Regional Development Act in West Virginia required the delineation of the State into subregions that would reflect a composite of numerous characteristics relating to social, political, economic and physical activities. As a result, the State was subdivided into nine regions consisting of multi-county units to provide a framework for coping with the multitude of social and economic problems, to encourage potential growth and generate activity if none existed. At the conclusion of the study, the Governor, by executive order, decreed that all planning for facilities and services in the State should conform with this area delineation. The three health facility plans follow this prescribed delineation, but to cope with specific problems encountered, it was necessary to create "catchment areas" within the regions to conform to the concept that health services should be provided at the community level.

The completed plans are presented to the appropriate advisory council for review and approval. Upon approval by the council, the plans are submitted to the State Board of Health for its comments and approval. Then the plans are advertised in newspapers and periodicals having a statewide distribution. Any interested agencies, groups or individuals may submit comments within 30 days from the date of publication. At the end of that period, the plans are transmitted to the United States Public Health Service for final review and approval. Upon final approval, available funds may be allotted by the State Board of Health to approved projects.

The combined effort of government, non-governmental and private agencies should result in the optimum of care at a minimum cost with the absolute minimum of duplication to all the citizens of West Virginia.

In the May 21 issue of "State of the State's Health" Doctor Dyer reported that the long awaited rubella control program will be instituted in West Virginia soon. Although rubella, or German measles, is a relatively mild disease in children, an expectant mother has a 50-50 chance of delivering a defective child if infected with rubella during the first three months of her pregnancy.

Some rubella cases occur each year; however, widespread rubella epidemics in the United States occur every six to nine years. Our last major rubella epidemic in 1964, was the largest in almost 30 years. As a result of the 1964 experience, it is estimated that 20,000 to 30,000 infants were born with severe birth defects. Should the six to nine year Rubella epidemic cycle persist, we can expect to see another increase in the German measles caseload as early as 1970 or as late as 1973.

Estimates of when rubella vaccine will be licensed and available range from May to September of 1969. Although it can only be a speculation at this time, Doctor Dyer feels confident that the State Department of Health should have a relatively good supply of rubella vaccine within six to eight months and it will be available through the Vaccination Program. This, of course, will depend upon the level of vaccine production and available funds which should be forthcoming.

Preventing infection of the fetus is the principal objective of rubella control. Because the vaccine has an unanswered, theoretical risk for the pregnant woman, the best means of protecting the fetus is by reducing the likelihood of rubella virus infection. This can best be done by eliminating the major source of infection for pregnant women; by eliminating the infection in children who are the principal reservoirs of the disease.

Dr. Dorman To Be Installed As AMA President

Dr. Gerald D. Dorman of New York City will be installed as President of the American Medical Association during the AMA's 118th Annual Meeting in New York City this month.

Many West Virginia physicians are expected to be among an estimated 60,000 persons who will attend the sessions July 13-17.

The inauguration of Doctor Dorman will take place on Wednesday, July 16, at 5 P. M. in the Imperial Ballroom of the Americana Hotel. He will succeed Dr. Dwight L. Wilbur of San Francisco.

Scientific Program

An elaborate scientific program has been arranged for the AMA meeting.

Many of the nation's leading physicians will present papers, and they will include Dr. Byron M. Bloor of Morgantown, Professor and Chairman of the Division of Neurosurgery at the West Virginia University Medical Center.

Doctor Bloor will participate in a "Symposium on Emergency Care of Neurosurgical Patients," to be held in the New York Coliseum on Thursday, July 17, beginning at 9 A. M. His topic will be "Emergency Room Management of the Patient With Head Injury."

(The complete scientific program for the meeting was published in the May 26 issue of *The Journal of the American Medical Association.*)

Doctor Hoffman Is Candidate

The West Virginia State Medical Association is pleased to sponsor the candidacy of Dr. C. A. (Carl) Hoffman of Huntington for the office of Vice Speaker of the AMA House of Delegates. The race for this important position has attracted at least four other prominent physicians.

Doctor Hoffman, a Past President of the West Virginia State Medical Association and the American Urological Association, has been a member of the AMA House of Delegates for many years. He also is a member of the AMA's important Council on Medical Service.

Business Sessions of House

The Opening Ceremony and First Session of the House of Delegates will be held on Sunday, July 13, beginning at 2 P. M. Subsequent sessions will be held on Tuesday, July 15, at 1 P. M.; Wednesday, and Thursday, July 16 and 17, at 9 A. M. All sessions will be in the Imperial Ballroom of the Americana.

Nine reference committees have been appointed to consider resolutions, reports and other business between sessions of the House. Doctor Hoffman has been named a member of Reference Committee F.

In addition to Doctor Hoffman, the West Virginia State Medical Association will be represented in the House of Delegates by Dr. Frank J. Holroyd of Princeton.

West Virginia's alternate AMA delegates are Drs. Thomas G. Reed of Charleston and Richard E. Flood of Weirton.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

July 2-7—Int. Col. of Surg., Lake Placid, N. Y.
July 13-17—AMA, New York.
July 18-19—Rocky Mtn. Cancer Conference, Denver.
Aug. 18-21—Am. Hosp. Assn., Chicago.
Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.
Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 20-21—W. Va. Hosp. Assn., White Sulphur Springs.
Oct. 24-26—Pot.-Shen. PG Inst., Martinsburg.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.
Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.
Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

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Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.
March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.
April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.
May 5-9—Am. Psychiatric Assn., San Francisco.
May 11-14—Am. Urological Assn., Philadelphia.
May 18-22—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.
June 21-25—AMA, Chicago.

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Cancer Palliation by Solid Tumor Chemotherapy (Part III)

Alvin L. Watne, M. D.

Table 8 lists the application of chemotherapy to some tumors of the skin and head and neck area. The lowly basal cell cancer, treated so many ways, yet so frequently recurrent and disastrous was shown by Goldman[66] to respond to a topical ointment of 20 per cent 5-fluorouracil with 3 per cent salicylic acid in neobase. Klein[67] has reported his experience with 30 solitary nodular basal cell carcinomas, where 21 tumor sites showed resolution with topical 5-fluorouracil lasting for 22 months. The response is best in the small (less than 15 mm. in diameter) superficial basal cell tumors. We have utilized a 20 per cent ointment of 5-fluorouracil in Aquaphor ointment applied daily, and have found this a valuable addition for the treatment of the small basal cell carcinomas, and for the palliation of pain, bleeding and drainage from the large lesions where further x-ray therapy or surgery was not feasible.

This is the third in a series of three articles by Doctor Watne which are being published in consecutive issues of The Journal.

Mycosis fungoides is a relatively rare but, unfortunately, malignant skin condition, characterized by slow progression and eventual death. Wright, Gumport and Golomb[68] reported on the successful application of methotrexate in treatmen of these patients. In a subsequent report[69] by these authors it was shown that nine of 16 patients adequately evaluated showed regression of their disease lasting up to 22.5 months.

Disseminated melanoma has remained a difficult tumor for the chemotherapist. Creech et al[70] developed a technique of regional arterial perfusion utilizing an extracorporal circuit that allowed high concentrations of an anticancer drug to come in contact with the tumor bearing area. The extremities were most adaptable for this technique, and melanoma was one of the tumors so treated. The literature is voluminous concerning application of the perfusion technique for treatment of various tumors. The recent summary by Krementz, Creech and Ryan[71] of their extensive experience is excellent. Utilizing 1-phenylalanine mustard 70 per cent of the patients showed an early objective response, frequently brief. The expenditure of time and effort was great, and the mortality rate, particularly in the poor risk patients was appreciable, approximately six per cent for the melanoma patients. Treatment of the primary disease by surgical means combined with perfusion resulted in an 82 per cent five-year survival free of disease. When the perfusion was palliative only for secondary disease, it still resulted in control of the disease in 26 per cent of patients after five years. In another large series of patients receiving perfusion therapy for melanoma, Stehlin[72] emphasized the problem of "in-transit metastasis" and reported that 70 per cent of patients suffering from such metastasis could benefit from perfusion therapy. We have utilized this technique infrequently, finding it complicated, costly

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and dangerous. We do not feel that it should be attempted without an oncology team who can concentrate on the many problems. It still leaves us with the problem of systemic metastasis from melanoma. Bloedow[73] had an optimistic report on the use of hydroxyurea in various tumors, including melanoma. He reported objective tumor responses in 10 of 15 patients with melanoma. Two recent reports by Nathanson and Hall[74] and Cassileth and Hyman[75] concerning the use of hydroxyurea for disseminated melanoma did not confirm these good results. Hopefully, further study will show the drug to be of value.

Palliation of recurrent squamous cell cancer of the head and neck region remains one of the most vexing problems facing the oncologist. Sullivan, Miller and Sikes,[34] in 1959, presented a technique for continuous intra-arterial infusion of an antimetabolite with systemic protection by an antagonist. This technique was elaborated upon by Sullivan[76] in 1962. He reported that 91 per cent of patients with squamous cell cancer of the head and neck area showed an objective response, with 28 per cent showing total disappearance of the tumor following therapy which persisted from five to 11 months. Watkins and Sullivan,[77] in 1964, reported on the use of continuous methotrexate infusion, 50 mg. daily with systemic leucovorin antidote, 6 mg. intramuscularly every six hours, and upon the use of 5-flourouracil 5.0 to 7.5 mg./kg. body weight every day and 5-fluoro-2-deoxyuridine 0.1 to 0.3 mg./kg. body weight per day. They generally used the methotrexate infusion first, and if the tumor was resistant, used a fluorinated pyrimidine. Of the 53 patients evaluated, 42 or 80 per cent showed an objective response, including 15 or 28 per cent with a complete remission lasting from three to 30 months. We have found this treatment to be very effective palliation giving objective responses to seven of 11 patients treated with the methotrexate-leucovorin.[78] It is, however, a complicated and dangerous procedure and should be undertaken only where time and attention can be paid to the technical problems. In the rare patient, tumor regression will occur so that curative surgery is possible, and this response must be kept in mind. We had one such patient and Nahum and Rochlin[79] reported this in six of 42 patients so treated. We have used the bedside Bowman infusion pump (Model #2). Watkins and Sullivan[77] describe the several different pumps available. Rush et al[80] have reported a simple technique for the self-administration of 5-flourouracil intra-arterially that has great promise in simplifying this palliative procedure. Of interest is Johnson's[81] report that the intra-arterial infusion of 5-flourouracil was less effective if the patient had received prior radiotherapy. The authors did not, nor do we, believe that infusion chemotherapy should supplant surgery or irradiation for these tumors, but rather be recognized as a valuable adjunct for palliation.

Systemic methotrexate has proven of some value in head and neck cancer. Papac et al[82] reported a 50 per cent tumor regression in 17 per cent of 24 patients treated with oral methotrexate, and using an intermittent intravenous methotrexate regimen reported tumor regression in nine of 15 patients.[83] Unfortunately, the duration of response was fairly brief for either method. Leone at al,[84] however, recently have reported similar favorable responses to intermittent intravenous methotrexate with a prolonged remission utilizing a three to four-week dosage schedule. Interest has centered also on the combination of drugs with irradiation for palliation of these tumors. Lerner et al[85] reported complete regression in 19 of 24 patients with epidermoid cancer of the head and neck treated with hydroxyurea 80 mg./kg/ every three days and concomitant radiotherapy. We have observed excellent palliation using this technique, but believe it still must be considered investigational.

Retinoblastoma represents an all too common malignant tumor that is transmitted by an autosomal dominant characteristic. Treatment was

Table 8

SOLID TUMOR CHEMOTHERAPY

Tumor	Drug(s)	Response	Duration
Skin			
Basal Cell	20% 5-FU	70%	1-22 mo.
Mycosis Fungoides	Methotrexate	56%	1-22 mo.
Melanoma	L-Phenylalanine Mustard (Perf. + Surgery)	82%	5 yr.
	L-Phenylalanine Mustard (Perf.-Palliation)	26%	5 yr.
	Hydroxyurea	(66%)	10-23 days
Squamous Cell	Methotrexate (I.A. with Leucovorin)	80-91%	3-30 mo.
	5-FU or 5-FUDR		
	Methotrexate (Oral)	17%	4-28 wks.
	Methotrexate (I.V.)	60%	1-4 mos.
Retinoblastoma	Tem (I.A. Adj.)	23-85%	5 yr.

Table 9

SOLID TUMOR CHEMOTHERAPY

Tumor	Drug(s)	Response	Duration
Breast	Diethylstilbesterol	36%	27 mo.
	Halotestine	16%	20 mo.
	Testosterone Propionate	21%	20 mo.
	5-FU	33%	9 mo.
Lung	HN_2	26%	1 yr.
Uterus			
Cervix	Methotrexate (I.A. $\overline{C}$ C.F.)	38%	4-18 mo.
Adenoca	Delalutin	33%	9-33 mo.
Choriocarcinoma & Mole Destruens	Methotrexate & Actino. D	75%	1-19 yr.

surgical, then combined with irradiation, and eventually with an alkylating agent, triethylenemelamine. Hyman, Ellsworth and Reese[86] have given a detailed report on their experience with this tumor. For patients with bilateral involvement they utilized enucleation of the most involved eye along with a 3500 rad tumor dose with Betatron therapy associated with 0.08 mg./kg. of triethylene-melamine given intramuscularly or intraarterially 24 hours before and after completion of the radiotherapy. Their results varied with the stage of the tumor, with apparent cure and useful vision resulting in 85 per cent of the early lesions, and 23 per cent of the advanced cases, and with Groups II, III and IV ranging from 50 to 68 per cent cure. This is a marked improvement over the 32 per cent five-year survival with adequate vision for patients treated by surgery and x-ray alone.[87]

Breast Cancer

Table 9 shows some remaining solid tumors that have shown a response to chemotherapy. Palliation of breast cancer is too large a subject to be covered adequately in this report, and the reader is referred to comprehensive reviews such as Donegan's.[88] We will confine ourselves to administration of exogenous hormones or drugs. In 1960, the Committee on Research of the American Medical Association[89] reported upon a retrospective study of the use of androgens and estrogens in disseminated breast cancer. Androgens gave objective remissions in 20 per cent of premenopausal women and 21 per cent of postmenopausal women. Estrogens were limited to postmenopausal women, and induced tumor regressions in 26 per cent of these patients. The oral drug diethylstibesterol was most frequently used. Both types of hormone were more effective in women eight years or more postmenopausal, and the estrogens proved equal or superior to androgens for soft tissue, skeletal or visceral metastases. Our experience with oral diethylstilbesterol in the postmenopausal patient has been equally rewarding, with objective remissions in 14 of 38 patients. Some insight into the relative value of the oral fluoxymesterone and the intramuscular preparation of testosterone propionate was given by the report of the Breast Cancer Group[90] in 1962. They reported a 21 per cent regression rate in 564 patients treated with testosterone propionate, 100 mg. three times weekly and a 16 per cent regression rate in 93 comparable patients treated with 20 mg. of flouxymesterone daily. We frequently use the oral preparation because of the ease of administration but cannot deny the value of the intramuscular drug. We have found hypercalcemia to be a relatively infrequent complication on hormone therapy, associated most often with hepatic involvement by tumor.

5-Flourouracil was shown to be of benefit for breast carcinoma patients by Ansfield et al.[25] They reported objective remissions in 33 per cent of their patients. Thiotepa has been used extensively in the treatment of breast cancer, and Silva et al[91] compared several chemotherapeutic drugs in the treatment of this disease. They observed objective remissions in 38 per cent of the patients treated with life-endangering lymphangitic spread of their tumor, and have observed gratifying results within 24 hours. Our usual application of the drug is after hormonal or ablative efforts have failed. Extreme care must be utilized in administering the drug to post-adrenalectomy patients as they tolerate any toxicity or complication poorly.

Lung Cancer

Lung cancer remains one of our most difficult therapeutic problems. A modest positive observation on this problem was made by Wolf, Yesner, and Patno[92] who observed a 26 per cent one-year survival rate for patients with squamous cell carcinoma of the lung treated with nitrogen mustard. This was better than the 5.5 per cent survival of similar patients receiving a placebo. No difference was noted in patients with other types of lung cancer.

The Cervix

Squamous cell carcinoma of the cervix has responded to the intra-arterial infusion techniques. Watkins and Sullivan's[77] series with infusion chemotherapy showed 11 objective responses in 20 patients with pelvic cancer including complete tumor regression in one patient. Lawton[93] described the use of aortic infusion chemotherapy via the percutaneous cannulation of the femoral artery with the Seldinger technique. We have used this technique for pelvic infusions, positioning the catheter at the aortic bifurcation under fluoroscopic control. We are pleased with the results. The complications are definitely less than the transabdominal placement of the catheters, the drug toxicity is not greater after prolonged infusion of methotrexate (25 mg. per day) with systemic coverage using leucovorin (3 mg. every six hours) and the tumor response is the same.

Tumor Response

Tumor response seemed related more to the duration of therapy, none arising with less than seven days of continuous infusions.[94] We had an objective and subjective response in 5 of 13

patients. The treatment, however, is dangerous. Three patients died of complications, and the response was fairly brief, two to four months in four, and 12 months in the fifth patient. Repeat infusion therapy seemed to be of little benefit. In general this technique can give effective palliation, especially pain and symptomatic relief, but is complicated and dangerous and is not recommended for general use.

Endometrial Carcinoma

The hormonal control of the secretory endometrium of the uterus made this a natural application for the control of endometrial carcinoma. Brendler et al[95] first reported the objective remission of endometrial cancer in seven of 22 patients treated with 17-alphahyroxyprogesterone caproate. The remissions lasted for as long as 4.5 years. Kennedy[96] reported a similar series in which eight of 27 patients treated with delalutin showed an objective response. Kistner et al[97] recently reviewed the problem and presented their observations with delalutin and depoprovera. The review of delalutin treated patients showed an objective response in approximately 33 per cent and the authors' series with depoprovera had an objective response in three of six patients. The authors' series was small, but they emphasize that patients who have a remission with one agent and develop recurrent tumor may respond to another progestational agent or an alkylating agent with a progestin. There are no known contraindications to progestational agents in the treatment of metastatic endometrial carcinoma and the side-effects are minimal.

In 1956, a report by Li, Hertz and Spencer[98] ushered in a new era in the treatment of choriocarcinoma and mole destruens in women. They demonstrated the effectiveness of intermittent therapy with a folic acid antagonist, methotrexate. While these lesions arise from an abnormal villus, and their clinical outcome is not predictable, Hreshchyshyn[99] reported a 95 per cent mortality in 42 patients with metastatic choriocarcinoma collected from the literature. Hertz et al,[100] in 1961, reported on their five years' experience in treating this tumor. They used methotrexate, 10 to 30 mg. intramuscularly daily for five days and measured both the metastatic disease and the urinary chorionic gonadotropin titers. Forty-eight per cent of the patients with choriocarcinoma and 47 per cent of those with chorioadenoma destruens showed complete remission of their disease. Prior hysterectomy made little difference upon the remission rate, although ovariectomy appeared to be more favorable. The authors suggested that ovariectomy be done only if hysterectomy was undertaken. The authors also found vincaleukoblastin to be effective along with the methotrexate. Hertz et al,[101] in 1964, reported upon 111 women treated with chemotherapy for metastatic trophoblastic disease. Sixty-four per cent of these 111 patients experienced complete and sustained remission. Of 87 patients treated initially with methotrexate, 51 per cent had complete and sustained remission. Twenty-three patients with incomplete remission were treated with actinomycin D, and 12 of these showed a complete remission giving a 75 per cent complete remission for treatment with methotrexate and actinomycin D. Twenty-eight women were treated with chemotherapy only for non-metastatic trophoblastic disease, six having choriocarcinoma by currettement. In four of the choriocarcinoma patients and 21 of the 22 patients with mole prompt and complete remissions occurred after one to four courses of methotrexate. This represents one of the outstanding triumphs of solid tumor chemotherapy.

Summary

Solid tumor chemotherapy has a role in treatment of the cancer patient. Proper selection of the patient and careful development of the chemotherapy regimen are important for the maximal benefit from the drugs available. Certain commercially available drugs appear to be of benefit in palliation of patients with specific tumors. Applying this treatment, a more effective, comfortable life may be obtained for these patients.

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Part III

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Generic Names

Mustargen: Mechlorethamine HC1, Merck and Co., Inc., West Point, Pennsylvania.

Thiotepa: TSPA, N, N^1, N^{11}—Triethylenethiophosphoramide, Lederle Laboratories Division, Pearl River, New York.

Cytoxan: Cyclophosphamide, N. N-bis (B- Chloroethyl)-N', O-propylene phosphoric acid ester diamide monohydrate, Mead Johnson Laboratories, Evansville, Indiana.

Leukeran: Chlorambucil, p-(di-2-chlorethyl) aminophenylbutyric acid, Burroughs Wellcome & Co., Tuckahoe, New York.

Alkeran: p-di(2-chloroethyl) amino-L-phenylalanine. Melphalan, Burroughs Wellcome & Co., Tuckahoe, New York.

TEM: Triethylenemelamine, 2, 4, 6, triethylenimino-s-triazine, Lederle Laboratories Division, Pearl River, New York.

Methotrexate: A-methopterin, 4-Amino-N^{10}-Methyl Pteroylglutoamic Acid, Lederle Laboratories Division, Pearl River, New York.

Calcium Leucovorin: Folinic Acid, Lederle Laboratories Division, Pearl River, New York.

Flourouracil: 5-Flourouracil, Roche Laboratories, Nutley, New Jersey.

Hydrea: Hydroxyurea, E. R. Squibb & Sons, New York, New York.

Cosmegen: Dactinomycin, Actinomycin D., Merck & Co., West Point, Pennsylvania.

Oncovin: Vincristine Sulfate, Eli Lilly & Co., Indianapolis, Indiana.

Atabrine Hydrochloride: Quinacrine hydrochloride, 6-chloro-9-(4-diethylamino-1-methylbutylamino) -2-methoxyacridine dihyrochloride, Winthrop Laboratories, New York, New York.

Testosterone Propionate in Oil: Testosterine propionate, Parke, Davis & Co., Detroit, Michigan.

Halotestin: fluoxymesterone, The Upjohn Co., Kalamazoo, Michigan.

Diethylstilbestrol Perles: diethylstilbestrol, The Upjohn Co., Kalamazoo, Michigan.

Estinyl :Ethinyl estradiol, Schering Corporation, Bloomfield, New Jersey.

Tace: Chlorotrianisene, Wm. S. Merrell Co., Cincinnati, Ohio.

Delalutin: 17-alpha-hydroxyprogesterone-n-caproate, E. R. Squibb & Sons, New York.

Dessicated Thyroid: Thyroid U.S.P.

Cytomel: L-triiodothyronine, Smith, Kine & French Laboratories, Philadelphia, Pennsylvania.

Synthroid: Sodium levothyroxine, Flint Laboratories, Inc., Morton Grove, Illinois.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

A Rapid and Prolonged Acting Corticosteroid For Acute Inflammatory Orthopedic Problems

George R. Clarke, M. D.

The rise in the number of patients with "cervical syndrome" due to hyperextension-hyperflexion injury with its attendant inflammatory soft tissue reactions such as tendinitis, fibrositis, myositis, or even arthritic-like symptoms is, of course, commensurate with the increase in the number of automobiles on the road.

Latest government statistics indicate that more than 25 per cent of our family population in the United States own two or more cars. With such statistics, it is obvious that this syndrome which, although a misnomer, has been called "whiplash" will continue to plague us for some time to come.

It is possible, however, to do something for many of these patients suffering from the effects of rear-end or head-on collisions or for patients with other inflammatory orthopedic problems by providing them with rapid and prolonged relief through the use of effective anti-inflammatory corticosteroids.

Among the newer corticosteroids is a specially prepared steroid combination containing the highly soluble betamethasone disodium phosphate for rapid action and a slowly released betamethasone acetate for sustained therapeutic action, i.e., a dual form of betamethasone (Celestone Soluspan)*.

Clinical evidence on the effectiveness of this dual betamethasone has been appearing in the literature.[1-5]

Patient Selection and Method

A study of this preparation was made in a total of 122 patients seen in our office practice. There were 43 men and 79 women ranging in age from 18 to 75 years. In addition to inflammatory soft tissue reactions due to automobile accidents and other post-traumatic complications, there were patients with the inflammatory effects of acute low back strain, inflammatory arthritic disturbances, and various types of bursitis. In short, they encompassed the usual variety of soft tissue inflammatory orthopedic problems seen in everyday practice.

*Product of Schering Corporation, Bloomfield/Union, N. J.

The Author

- **George R. Clarke, M. D., 1413 Eoff Street, Wheeling, W. Va.**

Injections were intramuscular, intrabursal, or intra-articular according to clinical judgment of the patients' needs. Dosage ranged from 1.5 cc. to 2 cc. as determined by the severity of the problem and the route of injection. The number of injections given was also judged by severity of the illness and duration of relief. In order to evaluate the preparation thoroughly, concurrent medications were kept at a minimum or avoided entirely if possible.

Results were graded excellent, good, fair or poor, according to rapidity of response, degree of relief and duration of relief. Table 1 illustrates the final analysis of these gradations.

Of the 122 patients, 66 received intramuscular injections, 29 intraarticular and 24 intrabursal. Two patients received intramuscular and intrabursal injections, and one was given both intramuscular and intraarticular injections.

The most marked response to the dual betamethasone was the speed with which it performed. Of the 122 patients treated, 102 experienced onset of action within the first three hours after injection. Patients had been asked to telephone or visit to give information about results, and most commented enthusiastically about the rapidity of relief. There were no complaints of untoward effects among those patients whose acute inflammatory orthopedic problem dictated a need for a corticosteroid despite relative contraindications. Two of these patients had a history of gastric ulcer, one had diabetes and osteoporosis, and five others had osteoporosis alone.

In 100 of the 122 patients in this study, the duration of relief lasted nine to twelve days to as much as six weeks. Table 2 depicts both onset and duration of action.

No secondary flare of pain was observed following injections, and there seemed to be less pain at the injection site than with other comparable preparations. As a matter of fact, patients who had previously refused or were reluctant to receive intrabursal or intraarticular injections did not object to use of this product.

Side-Effects

Side-effects were categorized as those believed to be due either to cortisone or of unknown origin. Those of doubtful origin included one patient with bursitis, who experienced thirst for 24 hours; dryness of the mouth, weakness of the voice for 48 hours; a "numb-like" skin sensation and "feeling stupid". One arthritic had a weight gain for 24 to 48 hours. Another patient complained of nausea but had had nausea and vomiting a week before treatment.

Although concurrent medications were avoided, clinical judgment required their continuance in some instances (Table 3).

Results, Comments and Conclusions

Our evaluation of the dual betamethasone is based on 122 patients treated for soft tissue inflammation associated with cervical syndrome ("whiplash") due to rear-end or head-on collision; bursitis of the shoulders and elbows or trochanter; acute myositis or inflammatory soft tissue disorders related to lumbar strain; arthritic conditions; and fractures or joint and muscle traumatic inflammatory episodes.

According to the results tabulated in Table 1, the dual form of betamethasone is highly effective and useful. One hundred five, or 86 per cent, of the 122 patients achieved excellent to good results with the preparation. Four, or three per cent, had a fair response, and only seven, or five per cent, were recorded as poor.

Its speed of activity (Table 2) found the majority, 101 or 83 per cent, registering pain-relieving effect within three hours.

Duration of action ranged from three to five days to as much as three to six weeks. The majority was in the 9-12 day category (56/122 or 45 per cent); the second highest in the 6-8 day classification (23/122 or 18 per cent); and third highest was in the 3-6 week group (21 or 17 per cent). These results confirmed earlier descrip-

Table 1

Evaluation of Response to Betamethasone Di Sodium Combined With Phosphate Betamethasone Acetate In Orthopedic Acute Inflammatory Problems

	Excellent	*Excellent to Good*	*Good*	*Fair*	*Poor*	*Lost to Follow-up*	*Total*
Bursitis	23	2	2	1		2	30
Inflammatory Arthritic Conditions	31		6	3	2	1	43
Inflammatory Trumatic Tissue Disturbances	28		4		3	1*	36
Other	7		2		2	2	13
Totals	89	2	14	4	7	6†	122

*This patient was taking Librium for nervousness and became more nervous after orthopedic treatment. Thus there was no grading of final response.

†Two of these moved from city but had immediate relief.

Table 2

Speed And Length Of Activity Of Betamethasone Di Sodium Combined With Phosphate Betamethasone Acetate In Orthopedic Problems

Inflammatory Category	*Onset of Action* 0-3 hrs	3-6 hrs	6-12 hrs	Lost to Follow-up or Unrecorded	*Duration of Action* 24 hrs	3-5 days	6-8 days	9-12 days	2 wks	3-6 wks	Lost to Follow-up or Unrecorded	Total
Bursitis	27	1		2			1	25		1	3	30
Arthritis	36	1	1	5		4	12	9	2	14	2	43
Trauma	29	2	1	4	1	1	6	19		5	4	36
Other*	9	1	1	2			4	3		1	5	13
Totals	101	5	3	13	1	5	23	56	2	21	14	122

*"Other:" Lumbosacral myositis (7); tennis elbow (1); hallus rigidus (1); temporal mandibular arthritis (1); disc related myositis (3).

tive reports in the literature of the preparation's speed and duration of effective therapeutic action.

Among the many important therapeutic uses for this form of dual betamethasone in our practice have been large numbers of patients with cervical syndromes, in which the acute inflammatory tissue disturbances are most common. Relief and normal action occur much faster in patients treated early with approximately 1.5 cc. of the drug. If necessary, repeated doses at 72 hours in severe complaints or at one-week intervals for three weeks often ease the problem markedly. In many of our patients we found that relief of these inflammatory states seemed to facilitate relief of pain. The response of many patients to the preparation seemed to reduce the hospital stay.

We have found this combined steroid a preparation of exceptional merit in the treatment of inflammatory disorders due to lumbosacral strain or arthritic disc problems of the lower back. In acute lumbar strain, the dual betamethasone (1.5 cc. IM) produced complete relief of pain within 12 to 24 hours in most patients. Relief of symptoms began within approximately three hours and continued to improve progressively. Duration of the effect lasted up to 36 hours or more, which was usually sufficient to relieve the acute condition.

There was generally prompt and excellent action in the intraarticular use of this corticosteroid in single joint problems. In some instances, however, although excellent intraarticular action for the first 48 to 96 hours was evident, the action usually was not sufficiently prolonged to institute the rehabilitative procedures necessary for restoration of the joint function.

It is particularly noteworthy that such inflammatory states of the so-called epicondylic bursitis of the elbow or "tennis elbow" seemed particularly responsive to successful treatment with this preparation. In the supraspinatus, infraspinatus and subscapularis types of bursitis of the shoulder, the product apparently equals other corticosteroids in therapeutic effectiveness.

Table 3

Concurrent Medication Used

Medication	*No. of Uses*
Testosterone Cypionate / Estradiol cypionate (Depotestadiol)	7
Methylprednisolene Acetate (Depomedrol)	12
Analgesics	8
Orphenadrine Citrate (Norflex)	4
Phenylbutazone / Prednisone (Sterazolidin)	2
Total	33

During the course of the evaluation, this dual corticosteroid was particularly helpful and valuable in treatment of traumatic inflammatory reactions without producing any untoward effects with doses of 1.5 cc. (IM) or less. Qualitatively, the preparation because of its dual effect seems to provide the orthopedic surgeon with a medication which relieves inflammatory reactions to a degree not possible before. In our hands, the dual betamethasone was an extremely potent and quick-acting type of corticosteroid of exceptional merit in the treatment of acute orthopedic inflammatory conditions. Its rapid action combined with a prolonged duration of effect enhances its worth markedly.

Summary

The corticosteroid described in this paper was used in 122 patients with a wide variety of inflammatory orthopedic problems seen in office practice. It was given in doses of 1.5 cc. to 2 cc. intramuscular, intrabursally or intraarticularly, as required. Results showed that this dual form of betamethasone provides rapid and sustained relief in a very high percentage of patients. Acute and chronic inflammatory reactions (myositis, tendinitis, and fibrositis) related to "whiplash" injuries, bursitis and a variety of traumatic episodes are particularly amenable to therapy with this preparation. I would like to note specifically that the rapid relief of the acute inflammatory state apparently seemed to produce a more than salutory relief of pain. Apparently the preparation serves to provide a means of breaking the cycle of pain-spasm-pain.

Betamethasone DiSodium Combined with Phosphate / Betamethasone Acetate — Celestone Soluspan

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Establishing Regional Rehabilitation Committees*

Glen P. McCormick, Ph. D., and W. E. Rankin, M. S.

REHABILITATION, as a concept, is being discussed with increasing frequency in West Virginia. Yet, in contrast to the rather universal acceptance of this topic, rehabilitation remains, for all practical purposes, an academic rather than a practical subject. Quite bluntly, unless positive steps are taken, West Virginia will enjoy no healthier rehabilitation status in the mid-1970's than it currently enjoys in 1968.

Rehabilitation is necessarily multidisciplinary in nature, involving a highly coordinated meshing of medical and paramedical disciplines. It is rarely simple in its effective operation, it is hardly inexpensive, and the heuristic aspect of the venture most often creates ever-expanding service responsibilities. Still, rehabilitation is perhaps man's best index of societal sophistication and, when studied closely, is infinitely less expensive than no rehabilitation at all.

If we are objective in our evaluation of the status of rehabilitation in West Virginia, we will have to admit that the vast majority of our State's populace receives relief via professional therapists too infrequently to be impressive. Witness the State's critical shortage of clinical psychologists, educational counseling and guidance experts, speech and hearing specialists, physical and occupational therapists, deaf educators, etc. Put very simply, the lack of such personnel explains in part why so many West Virginians are involved only on the fringes of today's society as noncompetitive unemployables.

The general situation surrounding the lack of rehabilitative specialists in West Virginia can be studied by considering, as a parallel, the availability of speech and hearing therapists.

*Presented by Doctor McCormick at a seminar on "Rehabilitation of Heart, Cancer and Stroke Patients," West Virginia University, Morgantown, September 20-21, 1968.

The Authors

- **Glen P. McCormick, Ph. D., Coordinator of Speech Pathology-Audiology, West Virginia University Medical Center.**
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Table 1 reveals the estimated number of speech and hearing defective persons in the nation and in the State, grouped according to age.

As can be determined from Table 1, West Virginia should expect to contain over 90,000 speech and hearing defective persons (re: minimally defendable incidence statistics). Of this number, over 24,000 would be of public school age.

In the spring of 1968 the writers conducted a special survey of speech and hearing specialists available in West Virginia. Table 2 reveals the deployment of these specialists, according to the nature of their employment.

Of significance from Table 2 are the following points:

1. One-ninth of the speech and hearing specialists in West Virginia are without clearly defined professional appointments, (i. e., housewives, occasional/part-time therapists and the like).
2. Seventeen per cent of the available work force are employed in colleges and universities, thus are not available for heavy service opportunities; and
3. West Virginia's public schools, estimated to contain at least 24,000 speech or hearing

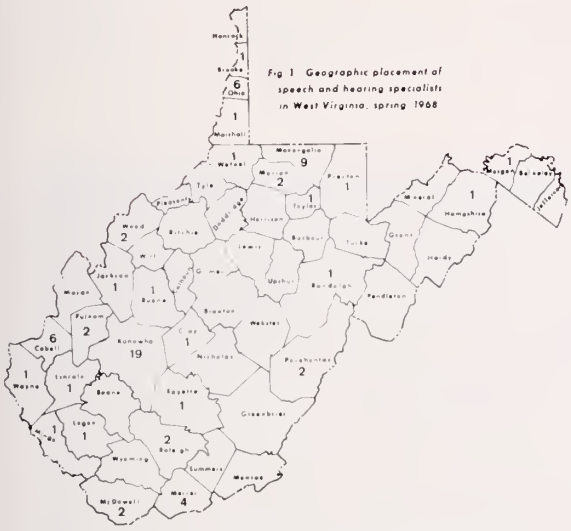
Table 1

Statistics from the 1959 Committee on Legislation for Combined Speech and Hearing Defects (Asha 9:9 (Sept.) 1960), as they relate to West Virginia.

Classification	*Proportion of defective total population*	*Age-group*	*Speech/Hearing Defects* U. S.	W. Va.
Pre-School	1.6%	< 4	312,500	2,977
School-age	5.7%	5-19	2,556,450	24,389
Adult	5.1%	20-64	5,569,200	53,134
Geriatric	5.1%	65 >	1,093,950	10,437
	Total		9,531,600	90,937

defective children, employ only 36 speech and hearing therapists (in only 24 of West Virginia's 55 counties).

Figure 1 reveals the geographic placement of these therapists within the State of West Virginia, demonstrating further that vast regions are without the services of speech and hearing specialists. The same is true, of course, for the variety of other rehabilitation disciplines discussed previously.



Not revealed by Tables 1 and 2 and Figure 1, is the fact that only two certified audiologists are presently working clinically in West Virginia. In fact, there appears to be only two sites in the State (Charleston and Morgantown) where sophisticated audiometrics are available.

To be both practical and realistic, suffice it to say that rehabilitation must be "local." It is unrealistic and expensive to assume that the special needs of ordinary people can be met by rehabilitators when the latter are associated with only the more metropolitan centers . . . as seems to be evident from Figure 1 with reference to speech and hearing specialists. While the writers are willing to acknowledge the difficulty involved in bringing rehabilitators to "local" availability, they are not willing to consider the task completely futile. As a result, the following suggestions are offered:

I. A formal rehabilitation committee, comprised of medical and rehabilitative specialists, should be formed for each of the nine regions defined by the West Virginia State Development Plan.

II. Each regional committee should devise a series of rehabilitation seminars designed to elucidate the rehabilitation needs of the particular region.

III. Each Regional Rehabilitation Committee should propose an achievable plan for implementing services within its respective region.

IV. Each Regional Rehabilitation Committee should promote immediately the establishment of rehabilitative services in the new and expanding medical services within its region.

V. A more formal association should develop between physicians and rehabilitators on a statewide level, perhaps via the West Virginia State Medical Association.

VI. As a long-range goal, West Virginia's physicians and rehabilitators should become more active in establishing health-oriented special education programs in all 55 West Virginia county school systems.

VII. Rehabilitative services in West Virginia should be removed from the realm of academics and made local realities for West Virginia's handicapped citizens.

VIII. Each Regional Rehabilitation Committee should strive to employ specialists only when they meet the certification standards of their given discipline.

Table 2

Classification of West Virginia speech and hearing specialists according to work environment; Spring, 1968.

	Schools	*Clinics*	*Colleges and Universities*	*Unknown/ Others*	*Total*
Number of Therapists	36*	16	12	8	72

*One year later, this population of specialists has decreased to only 23.

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102nd ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 21-23, 1969

PLAN NOW TO ATTEND

A message from . . .

The President

VALEDICTORY

At this time I am near the end of my duties as President of your Association. It has been a most enjoyable year. The doctors and their wives throughout West Virginia were perfect hosts when I visited the various societies. I have tried during the year to bring forth the problems that are facing us and to keep the doctors of West Virginia informed concerning national and state issues. I certainly can say that I have received the utmost cooperation from all concerned, including our office staff.

Perhaps this was a year that we were not faced with any momentous decisions and perhaps I was lucky in this way. In conclusion, I would like to thank all the physicians for allowing me to serve them during the year 1968-69.

Richard W. Corbitt, M.D.

Richard W. Corbitt, M. D., *President*

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EDITORIALS

THE 102nd

This issue of *The Journal* outlines in detail the program for the 102nd Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-23.

As usual, the Program Committee has put together a scientific program which should be of interest to all practitioners in attendance. In anticipation of a highly successful meeting the Editorial Board offers sincere congratulations to the following members of this year's Program Committee: Dr. Jack J. Stark of Parkersburg, the Chairman; and Drs. A. B. Curry Ellison and Seigle W. Parks of Charleston; I. Ewen Taylor of Huntington; and Herbert E. Warden of Morgantown.

It is our understanding the Committee experienced very little difficulty in obtaining as speakers some of the most prominent physicians and surgeons in the country. Add to the list the names of the Governor of the State of West Virginia and the President of the American Medical Association and you have a program which indeed promises an interesting three days.

Gov. Arch A. Moore, Jr., who has many friends among the medical profession throughout the State, will deliver an address at the opening of the First General Session on Thursday morning, August 21.

Dr. Gerald D. Dorman, who was installed as President of the American Medical Association at the Annual Meeting in New York City last month, will be the principal speaker at the first session of the House of Delegates, Wednesday afternoon, August 20. His visit to West Virginia

Richard W. Corbitt, M. D.
President

will be the first of many official visits to state associations throughout the coming year.

We look forward to having both Governor Moore and Doctor Dorman with us and hope they will be able to remain throughout the meeting.

Other guests will include the presidents of the state medical associations in the neighboring states of Ohio, Pennsylvania, Maryland and Kentucky. It is a privilege for us to annually entertain these physicians and their wives from across the borderlines.

One of the features of the meeting will be a Seminar on "Insurance and Investments for Physicians" which has been scheduled for Thursday afternoon. Dr. C. A. Hoffman, Chairman of the Insurance Committee, will serve as moderator and one of the speakers will be a native son, Dr. Thomas S. Sexton, who was born in Sistersville and attended West Virginia University. He is currently Senior Vice President of the Massachusetts Mutual Life Insurance Company.

Another participant in the Insurance and Investment Program will be Dr. Edward R. Annis of Miami, a Past President of the American Medical Association. This will be his fourth appearance at our annual meetings in recent years. He recently became President and Chief Executive Officer of the Denver Corporation, an investment firm in the oil and gas field.

Dr. Richard W. Corbitt, the President, will deliver his final address as President of the Association at the second session of the House of Delegates on Saturday afternoon. The occasion will mark the end of 12 months of loyal service to the Association and its members. The Parkersburg urologist has traveled far and wide during his term of office and has made many friends for the Association not only in the State but throughout the country.

Although the burden on Doctor Corbitt will be eased somewhat, he still will be challenged with the responsibility of serving as Chairman of the Council during the coming year. We wish him well and pledge our continued support and cooperation.

Dr. Maynard P. Pride of Morgantown will be installed as President succeeding Doctor Corbitt. He served several terms as a member of the Council prior to being named Vice President in 1967 and President Elect in 1968. His deep involvement in the affairs of organized medicine stand him in good stead for handling the responsibilities of the office of President.

During the meeting at The Greenbrier we hope it will be possible to introduce Dr. Carl Hoffman as a new member of the Board of Trustees of the American Medical Association. He was a candidate for that office in an election held at the final session of the AMA House of Delegates in New York City last month.

Once again the Woman's Auxiliary will be in charge of the entertainment program and a dance will be held in Chesapeake Hall on Friday night. This is the highlight of the social program and physicians, their wives, guests and representatives of our industrial exhibits are cordially invited to attend.

Another function open to all in attendance is the Saturday evening cocktail party and reception honoring officers of the State Medical Association. It will be held on the Chesapeake Hall Terrace and prizes will be awarded to winners of the golf tournament at that time.

We are pleased to report that there will be a record number of industrial exhibitors in the Exhibit Center. These firms spend large sums of money to display their exhibits and it behooves all physicians in attendance to spend several hours discussing products and recent therapeutic developments with our friends the exhibitors. We also understand several of the scientific exhibits will be of unusual interest.

All in all, it is certain the 102nd will rank among the finest and well-attended annual meetings in the long history of the Association. It is anticipated that more than 700 persons will attend so we urge you to make your reservation just as soon as possible.

We'll see you at The Greenbrier!

LETTERS TO THE EDITOR

Your recent letter about young physicians and their wives was most thought provoking, and I have been pondering what we as an Auxiliary can do to help. For the past several years Mrs. Clark K. Sleeth, our WASAMA liaison, has urged our members to seek out young medical students and their wives and become acquainted, invite them to join their meetings or visit in their homes during vacations. Perhaps we have not followed through on these suggestions as we should have, but from now on we will give them the attention they deserve.

Mrs. Sleeth recently appeared in Morgantown before the Caduceanns Chapter and gave a little "pep talk" which she called "Don't Sell West Virginia Short." In it she reminded the girls of the advantages of living in West Virginia, with the progress it is making in many fields, and pointed out some of the drawbacks of living in many other states.

This is what we have done so far. I will surely bring this problem before our Executive Board and convention this summer, and we will make a special effort to cooperate with you from now on.—*Mrs. John A. B. Holt, Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association.*

I received your recent communique with joy and enthusiasm. Thank you for sending it to me. Not only will your thought-provoking suggestions fit into our program for the coming year, but they will, in a sense, serve as a rallying point and a source of motivation for us.

Vague though I am at this point in how exactly to carry it out, I am in the process of formulating a program to "upgrade" not only West Virginia but America as well. The apathy, the lack of concern on the part of Americans in general and West Virginians in particular regarding their glorious, though perhaps not perfect, heritage saddens and angers me. An American by choice, I am able to judge without bias the greatness of America, marvel at her opportunities, and appreciate unreservedly the beauty of her land and the goodness of her people. Voices in favor of West Virginia—and of America—must be raised and heard. What better tool through which this may be accomplished than the Medical Auxiliary?

A liaison between our State Auxiliary and WASAMA already exists, and the Auxiliary pays the expenses of the president of WASAMA to our Board meeting in order that she may learn the things we stress, the promotion of good health and the establishing of love and understanding between physicians' families and between them and the community as a whole. Ought this not to include future physicians' families as well?

The incoming president of WASAMA, like me a Fayette countian, plans to attend the State Auxiliary Fall Board Meeting. I am looking forward with eagerness to spending some time with her in order to get suggestions on how we of the State Auxiliary may better serve not only WASAMA but SAMA as well.

We will need support and encouragement in our "upward" program both from *The Journal* and from our physicians, and I know you will accord us every consideration in our efforts to upgrade and make life in West Virginia more attractive to the future physician and his wife.

Again I thank you for bringing this great need to the attention of the State Auxiliary. I extend warm, good wishes for the continued success of your work.—*Mrs. Joe N. Jarrett, Oak Hill, President Elect of the Woman's Auxiliary to the West Virginia State Medical Association.*

The Dilemma of Computer Medicine

At the recent National Congress on the Socio-Economics of Health Care, one of the speakers advocated using computer programming in taking medical histories and in arriving at diagnoses, a process which would provide simultaneously a permanent record of the patient's history and treatment.

He cited as advantages of this technique the time saved by the physician and the greater accuracy of a history taken from a standard programed list of questions. A further advantage would be the availability of the patient's history and a record of his treatment to any physician who might subsequently treat him.

While computer medicine has some obvious advantages in both speed and accuracy, some equally obvious questions arise as to its practicability. Computers are expensive and would be feasible only where they are readily available to large groups of physicians and patients. Since they are only as accurate as the humans who program them, there would be need for a large number of very highly skilled technicians. How soon would they be available in numbers large enough to make mechanical medicine available to any great share of the population?

Another question that must persist in the minds of physicians and patients alike is this: Would even a "medical machine" make some of the silly mistakes that are made daily by those in use in schools, businesses, and airline offices?

Would too great a reliance on computer diagnosis impair the medical judgment of those physicians who might suddenly find themselves without its services?

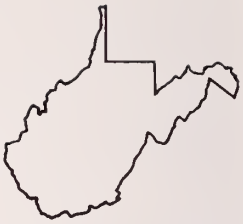
Because the growth of medical knowledge and of the population is placing ever-increasing demands on the time and the skills of the physicians, it is essential that we avail ourselves of every technical advance to help us bring better medicine to more people. However, let us beware of the delusion that a computer can replace a competent, conscientious physician who daily must deal with the whole gamut of human distress.

To quote the quite elderly patient of an elderly physician: "I don't know what I will do if my doctor ever retires. When he comes to see me, he takes my pulse and listens to all my complaints. Then he gives me some kind advice—and I feel so much better. What more can you expect at my age?"

Can the impersonal analysis of a mechanized brain be equated with the sympathetic, human understanding of a personal physician?—*W. D. James, M. D., in The Wisconsin Medical Journal.*

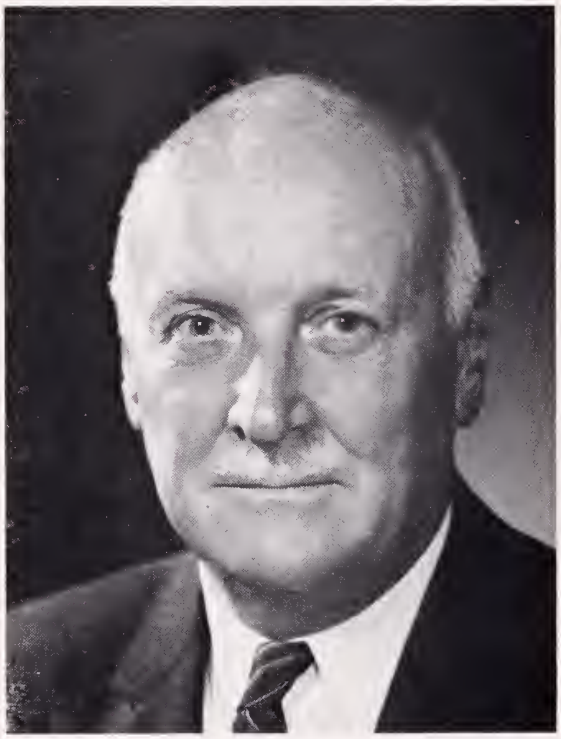
There are a number of complex scientific problems about the marketing of safe drugs that are still unresolved, although drug industry and other scientists are constantly working on these problems. It may be the nature of biological systems that absolute safety will never be attained. It must be left to the physician to weigh the possible advantages over any known disadvantages. Both the manufacturer and the government now take every appropriate precaution to assure the marketing of safe pharmaceutical products.

GENERAL NEWS



Gov. Moore, Dr. Dorman Guests At 102nd Annual Meeting

Gov. Arch A. Moore, Jr., and Dr. Gerald D. Dorman, President of the American Medical Association, head a list of prominent physicians and laymen who will speak during the 102nd Annual Meeting of the West Virginia State Medical Association this month.



Gerald D. Dorman, M. D.
AMA President

The meeting will be held Thursday through Saturday, August 21-23, at The Greenbrier in White Sulphur Springs.

Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee, announced that Doctor Dorman, of New York City, would address the opening session of the House of Delegates on Wednesday afternoon, August 20, the day preceding the formal opening of the convention. Doctor Stark also said that Governor Moore would present an address at a session marking the formal opening of the convention on Thursday morning, August 21.

Doctor Dorman was installed as President of the AMA during the national organization's annual convention in New York City last month. A native of Beirut, Lebanon, where his father was Dean of the School of Medicine of the American University, Doctor Dorman came to this country at the age of 17.

He received his M. D. degree from Columbia University in 1929 and was elected to the AMA Board of Trustees in 1960. In 1966, he became Secretary-Treasurer of the AMA and Secretary of the Board of Trustees. He was elected to the office of President Elect during the AMA annual meeting in June, 1968.

Address by Governor Moore

A lawyer by profession, Governor Moore served for 12 years in the U. S. House of Representatives prior to his inauguration as the 28th Governor of West Virginia last January.

He is a native of Moundsville and received his early education in the public schools of Marshall County. He was graduated from West Virginia University and received his law degree in 1951.

All persons registered for the Annual Meeting are cordially invited to hear Governor Moore's address on Thursday morning, August 21, and the address by Doctor Dorman before the House of Delegates the preceding day.

Presidential Address

Dr. Richard W. Corbitt of Parkersburg, retiring President of the West Virginia State Medical Association, will present his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 23.

Pre-Convention Meetings

Important pre-convention meetings include sessions of the Council and the House of Delegates of the State Medical Association. The Council will meet at 10 A. M. on Wednesday, and the House will have its first session at 3 o'clock that afternoon.

The 1969 Program Committee

Dr. Jack J. Stark of Parkersburg is Chairman of the Program Committee for the 102nd Annual Meeting of the West Virginia State Medical Association.

Other members of the Committee are: Drs. A. B. Curry Ellison and Seigle W. Parks, both of Charleston; Dr. I. Ewen Taylor of Huntington; and Dr. Herbert E. Warden of Morgantown.

The registration desk will be open in the main floor lobby of The Greenbrier from 8:30 A.M. to 5 P.M. each day during the convention.

General Scientific Sessions

The three general scientific sessions will be held in Governor's Hall in the West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies will be held in Governor's Hall and the nearby Mountaineer Room, while other meetings will be held in the Convention Unit.

Industrial and scientific exhibits will be located in the Exhibit Center in the West Virginia Wing outside Governor's Hall and the Mountaineer Room.

Scientific Motion Pictures

Scientific motion pictures will be shown in Governor's Hall each morning during the convention prior to the opening of the Scientific Session. Dr. John J. Mahood of Bluefield is Chairman of the Committee that has arranged for the showing of the sound films.

Formal Opening of Convention

Doctor Stark will call the convention to order at 9 A.M. on Thursday in Governor's Hall. Doctor Corbitt will deliver the address of welcome, and the first speaker on the program will be Governor Moore.

Dr. Seigle W. Parks of Charleston, a member of the Program Committee, will serve as Moderator for the First General Scientific Session, which will follow Governor Moore's address. The guest speakers and their topics are as follows:

Maj. Gen. Joe M. Blumberg (MC), Commanding General, United States Army Medical Research and Development Command, Washington, D. C. Subject: "Some Interesting or Unusual Cases in Forensic Pathology."

Albert B. Ferguson, Jr., M. D., Professor and Chairman of the Department of Orthopedic Surgery at the University of Pittsburgh School of Medicine. Subject: "Degenerative Arthritis of the Hip—What It Is and the Modern Methods of Taking Care of It."

Francis M. Forster, M. D., Professor and Chairman of the Department of Neurology at the University of Wisconsin School of Medicine. Subject: "Behavioral Treatment of Epilepsy—1969."

Immediately following the presentation of his paper, Doctor Blumberg will address a meeting of the West Virginia Association of Pathologists in the Mountaineer Room.

Luncheon for Past Presidents

A luncheon honoring past presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 21, during the 102nd Annual Meeting.

Dr. Richard V. Lynch, Jr., of Morgantown, Immediate Past President, will preside, and invitations have been extended to all of the Association's living past presidents.

Maynard P. Pride, M. D.
President Elect

Thursday Afternoon Program

Headlining the Thursday afternoon program will be a Seminar on "Insurance and Investments for Physicians." This session will begin at 3 P. M. in the Fillmore and Van Buren Rooms, with Dr. C. A. (Carl) Hoffman of Huntington, Chairman of the State Medical Association's Insurance Committee, serving as Moderator.

Participants will include: Dr. Edward R. Annis of Miami, Florida, President of The Denver Corporation; Mr. E. H. Morgan of Hartford, Connecticut, Assistant Secretary, Underwriting Department in the Casualty and Surety Division of Aetna Life and Casualty Company; Dr. Thomas S. Sexton of Springfield, Massachusetts, Senior Vice President of the Massachusetts Mutual Life Insurance Company; and Mr. J. Banks Shepherd of Charleston, Administrator of the State Medical Association's Group Insurance Program.

Dr. Richard E. Flood of Weirton will preside at a meeting of the Resolutions Committee at 2 P.M. on Thursday in the West Virginia Room. At the same time, there will be an Open Meeting of the West Virginia State Society of Allergy in Governor's Hall, with Dr. Grover C. Hedrick of Beckley presiding.

Second General Scientific Session
Friday Morning

Dr. A. B. Curry Ellison of Charleston will serve as Moderator for the Second General Scientific Session on Friday Morning, August 22, when the speakers and their topics will be as follows:

Hon. Arch A. Moore, Jr.
Governor of West Virginia

Kermit E. Krantz, M. D., Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center. Subject: "The Placenta—Man's Best Friend."

Raymond J. Jackman, M. D., Head of the Section of Proctology at The Mayo Clinic, Rochester, Minnesota. Subject: "Crohn's Disease."

Felix de la Cruz, M. D., Chief, Children's Diagnosis and Study Branch of the National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland. Subject: "Physicians' Role in Mental Retardation."

Friday Afternoon Program

Most of the societies and sections affiliated with the State Medical Association will have business and scientific sessions on Friday afternoon. The schedule of these meetings is as follows:

Dr. Bruce C. Sinclair-Smith of Nashville, Tennessee, will present a paper on "Evaluation of Valvular Heart Disease" to the Section on Internal Medicine. Dr. James T. Hughes of Ripley will preside.

Dr. Forest A. Cornwell of Beckley will preside at a meeting of the Section on Pediatrics. The guest speaker, Dr. Felix de la Cruz, will address the pediatricians on the subject of "The High-Risk Infant."

Dr. Harold N. Kagan of Huntington will preside over the Section on Urology. Dr. C. A. (Carl) Hoffman of Huntington will speak on "Socio-Economic Problems in Urology," and the program also will include a Pyelographic Conference on Interesting Urological Cases.

Dr. Alvin L. Watne is to preside at the meeting of the Section on Surgery, which will hear two speakers, Dr. Raymond J. Jackman of Rochester, Minnesota, and Dr. W. Glenn Young, Jr., of Durham, North Carolina. Doctor Jackman will speak on "Office Management of Anorectal Disease," while Doctor Young will present a paper on "Surgery in Non-Tuberculous Pericarditis."

Dr. Andrew W. Goodwin, II, of Charleston will preside at the meeting of the West Virginia Radiological Society. The radiologists will hear Dr. C. Douglas Maynard of Winston-Salem, North Carolina, speak on "The Uses of Radionuclides in the Evaluation of the Central Nervous System."

Dr. Francis M. Forster of Madison, Wisconsin, will address the Section on Neurology, Neurosurgery and Psychiatry on the subject of "Reading Epilepsy." Dr. Thomas J. Holbrook of Huntington will preside at the meeting.

"The Transmission of Local Anesthetic Drugs from Mother to Fetus" will be the subject of a paper to be presented by Dr. E. M. Papper of New York City at a meeting of the West Virginia Society of Anesthesiologists. Dr. E. L. Linger of Clarksburg will preside.

The West Virginia Obstetrical and Gynecological Society will have as its speaker Dr. Kermit E. Krantz of Kansas City, Kansas. His topic will be "Quo Vadis Feminines?" or the "Changing Pattern of the American Woman." Dr. Robert Greco of Morgantown will preside at the meeting.

Dr. John P. Griffith of Wheeling will preside at the meeting of the Section on Orthopedic Surgery. Dr. Albert B. Ferguson, Jr., of Pittsburgh, will speak on "Skeletal Trauma in Children."

Dr. Edward Shupala of Parkersburg will conduct a business meeting of the West Virginia Academy of Ophthalmology and Otolaryngology. No scientific session is planned.

Convention Timetable

The first general scientific session will begin at 9 A.M. on Thursday, August 21. The Friday session will begin at 9:30 A.M. and the session on Saturday at 9 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 20, beginning at 3 o'clock. The second session will be on Saturday afternoon beginning at 2:30 o'clock.

The Exhibit Center will be open from 8:30 A.M. to 3:30 P.M. on Thursday and Friday and from 8:30 A.M. to 1 P.M. on Saturday.

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 3 P.M. on Wednesday, August 20. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 23.

All of the section meetings listed above will begin at 2 P.M.

The West Virginia Chapter of the American Society of Internal Medicine will meet at 3:30 P.M., with Dr. R. U. Drinkard of Wheeling presiding. Meeting at the same time will be the West Virginia District Branch of the American Psychiatric Association. Dr. Roy A. Edwards of Huntington will preside.

The Committee on Nominations will meet at 5 P.M. Dr. Richard E. Flood of Weirton is Chairman.

Third General Scientific Session Saturday Morning

The Third General Scientific Session will begin at 9 o'clock on Saturday morning. The lead-off speaker will be Dr. Ludwig Gutmann, Associate Professor and Acting Chairman of the Department of Neurology at the West Virginia University Medical Center. His subject will be "L-Dopa Therapy of Parkinson's Disease—A Review of Preliminary Experience at West Virginia University."

Following Doctor Gutmann's presentation, there will be a "Symposium on Cardio-Respiratory Emergencies and Their Management." Moderator will be Dr. Herbert E. Warden of Morgantown and speakers will include Dr. E. M. Papper of New York City; Dr. Bruce C. Sinclair-Smith of Nashville, Tennessee; and Dr. W. Glenn Young, Jr., of Durham, North Carolina.

Second Session of House of Delegates

The second and final session of the House of Delegates will be held on Saturday afternoon, beginning at 2:30 o'clock. Doctor Corbitt will preside and will present his Presidential Address.

Other features of the final session will include the installation of Dr. Maynard P. Pride of Morgantown to succeed Doctor Corbitt as President; election of other new officers; and presentation of a check representing physician contributions to the West Virginia University School of Medicine through the AMA-ERF Program. Dr. Clark K. Sleeth, Dean of the School, will accept the check.

Medical School Alumni Parties

The Alumni Associations of two medical schools will hold cocktail parties during the meeting.

Dr. James P. Baker of White Sulphur Springs is in charge of a cocktail party to be sponsored by the University of Virginia Alumni Fund, Medical Division, on Thursday evening beginning at 6 P.M. Beginning one-half hour later will be the cocktail party of the West Virginia Chapter, Medical College of Virginia Alumni Association. Dr. Jean P. Cavender of Charleston is in charge of arrangements.

No Convention Registration Fee

No registration fee will be charged either members or guests in connection with the 102nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23, 1969.

Nominating Committee To Meet On Friday, August 22

The Committee on Nominations of the State Medical Association will meet on Friday, August 22, during the Annual Meeting at The Greenbrier.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, nominees for the offices of President Elect, Vice President, Treasurer, and Delegate to the American Medical Association and Alternate Delegate.

The By-Laws of the Association specify that additional nominations may be made from the floor for the various offices.

Dr. Richard E. Flood of Weirton will serve as Chairman of the Committee on Nominations. Other members of the Committee were elected during the Summer Meeting of the Council, and they are as follows: Dr. Harry S. Weeks, Jr., of Wheeling; Dr. George A. Curry of Morgantown; Dr. Robert W. Bess of Piedmont; Dr. Andrew J. Weaver of Clarksburg; Dr. Robert L. Chamberlain of Buckhannon; and Dr. A. Thomas McCoy of Charleston.

Auxiliary Dance on Friday Night

A "Topiary Garden Ball" will be held Friday night in Chesapeake Hall beginning at 10 o'clock. The Woman's Auxiliary is sponsoring the dance.

Saturday Evening Reception

A cocktail party and reception honoring the new officers of the West Virginia State Medical Association will be held from 6:30 to 7:30 P.M. Saturday on the Chesapeake Hall Terrace. All members of the Association and the Auxiliary and their families, representatives of the industrial and scientific exhibitors and convention guests are cordially invited to attend the reception.

Industrial and Scientific Exhibits

What is believed to be a record number of industrial and scientific exhibits will be on display during the meeting in the Exhibit Center. Physicians, members of the Auxiliary and their guests are urged to visit the Exhibit Center, which will be open each day from 8:30 A.M. to 3:30 P.M.

Heavy Registration

As usual, advance registration for the meeting has been heavy. More than 600 persons had made reservations at The Greenbrier as this issue of *The Journal* went to press, and total registration is expected to exceed 700.

Looking Back 10 Years . . .

Mr. Aubrey Gates of Chicago (standing) was principal speaker at a legislative meeting sponsored by the State Medical Association in Charleston in 1959. At the time, Mr. Gates was Director of the American Medical Association's Field Service Division. At left is Mr. Joe Miller of Chicago, then AMA field representative and presently Director of the AMA Division of Public Affairs. At right is Dr. Frank J. Holroyd of Princeton.

Insurance and Investments Seminar At Annual Meeting

A Seminar on "Insurance and Investments for Physicians" will be conducted during the 102nd Annual Meeting of the West Virginia State Medical Association on Thursday afternoon, August 21, beginning at 3 o'clock.

Dr. C. A. Hoffman of Huntington, Chairman of the Association's Insurance Committee, will serve as Moderator for the program and the discussion will center around the following subjects: the problem of sky-rocketing malpractice claims—and possible solutions; recent changes in HR 10 (Keogh Law)—tax saving under the new law; a unique investment plan in the gas and oil industry; and life insurance for physicians.

Participating in the program will be the following qualified experts in their respective fields:

Edward R. Annis, M. D., Miami, Florida, President, The Denver Corporation.

Mr. E. H. Morgan, Hartford, Connecticut, Assistant Secretary, Underwriting Department, Casualty and Surety of Aetna Life and Casualty Company.

Thomas S. Sexton, M. D., Springfield, Massachusetts, Senior Vice President of the Massachusetts Mutual Life Insurance Company.

Mr. J. Banks Shepherd, Charleston, President of McDonough-Caperton-Shepherd-Goldsmith Insurance Agency, and Administrator of the Group Insurance Program of the West Virginia State Medical Association.

Doctor Hoffman announced that the formal presentations will be brief to provide ample time for a question and answer period.

Medical Golf Tournament Is Annual Meeting Feature

One of the more popular extracurricular events during the 102nd Annual Meeting of the West Virginia State Medical Association this month will be the Medical Golf Tournament.

A beautiful trophy is awarded to the winner by Hospital and Physicians Supply Company of Charleston. A physician who wins three tournaments gets to keep the trophy.

Dr. Robert S. Wilson of Clarksburg won the tournament with a 75 last year.

Other low gross scores last year included: Dr. Joseph T. Mallamo of Fairmont, 76; Dr. George A. Curry of Morgantown, 78; Dr. J. Paul Aliff of Charleston, 79; and Dr. W. C. Morgan of Charleston, 80.

Dr. Joseph A. Smith of Dunbar will serve as Tournament Chairman once again. He said that physicians participating in the tournament must pay an entry fee of $5. Physicians may participate in tournament play both mornings and afternoons during the three-day meeting.

Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by 4 P. M. on Saturday, August 23.

Dr. Hogan Is Certified

Dr. Gwendolyn R. Hogan of Morgantown has been certified in neurology "with special competence in child neurology" by the American Board of Psychiatry and Neurology.

Doctor Hogan has been a Diplomate of the Board for several years but the citation of "special competence in child neurology" was awarded recently under a new program inaugurated by the Board last year.

Doctor Hogan is Assistant Professor of Pediatrics and Neurology at the West Virginia University Medical Center.

ASA Inducts Doctor Pittman

Dr. Robert R. Pittman of Martinsburg recently became a Fellow of the American Society of Anesthesiologists. He is a member of the Eastern Panhandle Medical Society and the West Virginia State Medical Association.

Postgraduate Institute Dates Are Changed

There has been a change in dates for the 14th Annual Potomac - Shenandoah Valley Postgraduate Institute in Martinsburg.

According to Dr. Halvard Wanger of Shepherdstown, the Institute will be conducted this year Friday through Sunday, October 31 through November 2, instead of October 24-26 as previously announced.

Assn. of Clinical Urologists Elects Doctor Hoffman

The new American Association of Clinical Urologists held its organizational meeting in San Francisco on May 9 and elected Dr. C. A. (Carl) Hoffman of Huntington as its first President.

Also participating in the first annual meeting of the new Association was Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association, who gave a "Report from Washington."

Doctor Hoffman is a Past President of the State Medical Association and recently served a one-year term as President of the American Urological Association.

Other officers of the new American Association of Clinical Urologists include: Dr. William Barrett of Pittsburgh, Vice President and President Elect; and Dr. Russell B. Carson of Fort Lauderdale, Florida, Secretary-Treasurer.

Sports Medicine Conference At Mont Chateau

A Symposium on Sports Medicine will be held at Mont Chateau, near Morgantown, on Friday and Saturday, September 19-20.

Sponsors are the Department of Surgery of the West Virginia University Medical Center and the West Virginia Chapter, American College of Surgeons. Dr. Richard A. Currie of Morgantown is in charge of arrangements.

Dr. John W. Trenton of Kingwood, President of the ACS Chapter, said the program would focus on the prevention of injuries, management of common athletic injuries, use of protective gear and physical conditioning. He said physicians, coaches, trainers and other interested persons are invited to attend.

Two orthopedic surgeons have accepted invitations to speak during the day and a half session, and other speakers are to be announced later. Dr. Fred L. Allman of Atlanta, Georgia, will give a talk on knee injuries, and Dr. Albert B. Ferguson, Jr., of Pittsburgh, will discuss physical conditioning.

The Saturday forenoon session will be completed in time for participants to attend the West Virginia University-Maryland football game.

Additional information may be obtained by writing to Dr. Richard A. Currie, Department of Surgery, WVU Medical Center, Morgantown, West Virginia.

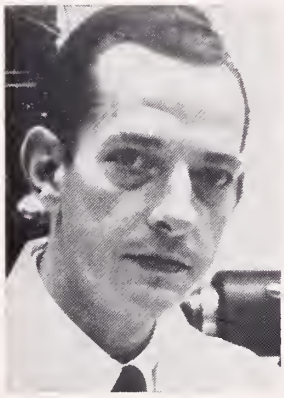
AHA Council Meets in Dallas

The American Heart Association's Council on Arteriosclerosis will have its 1969 scientific meeting in Dallas, Texas, November 11-12.

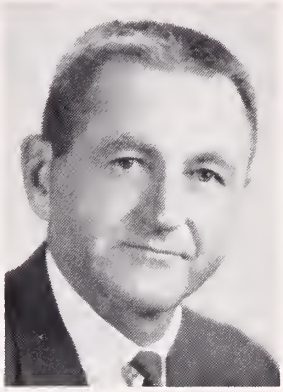
The meeting immediately precedes the Heart Association's four-day Scientific Sessions program in the Dallas Memorial Auditorium. All interested physicians and other scientists are invited to attend.

Four Speakers Are Announced For Bluefield Seminar

Three physicians and a layman have accepted invitations to speak during the Seventeenth Annual Seminar at the Bluefield Country Club on October 16.



Hugh Davis, M. D.



John P. Wilbern

The program is sponsored by the Bluefield Sanitarium, the Stevens Clinic in Welch and the Clinch Valley Clinic in Richlands, Virginia.

Scientific papers will be presented beginning at 2 P.M. There will be a social hour and dinner beginning at 5 P.M.

After-dinner speaker will be Mr. John P. Wilbern, Administrator of the President's Council on Physical Fitness and Sports. He will speak on the mission and goals of the Council.

Medical speakers will include Dr. Hugh Davis of the Department of Obstetrics and Gynecology, Johns Hopkins University Hospital in Baltimore; Dr. William B. Kieswetter of the University of Pittsburgh School of Medicine; and Dr. Henry F. Warden, Jr., of the Bluefield Sanitarium's Department of Internal Medicine.

Additional information about the seminar may be obtained by writing to Dr. Frederick T. Edmunds, Bluefield Sanitarium Clinic, Bluefield, West Virginia.

American Medical News Makes Debut

The *American Medical News* made its debut on July 7 as successor to *The AMA News.*

The American Medical Association Board of Trustees recently approved the change in name "with redirection of its editorial content so that it is not entirely a newspaper reporting on AMA activities but one that will become a source of balanced treatment of any news of importance to medicine."

AMA News began as a bi-weekly in 1958 and went weekly in 1965. It grew from an initial circulation of 224,450 to 350,000. It is distributed to physicians, students in the final three years of medical school, members of allied health professions and others.

Although *American Medical News* will take new approaches in makeup as well as editorial content, it will retain the tabloid format. Marvin L. Rowlands continues as editor, a position he has held since 1966.

Summer Meeting of the Council In Charleston on June 22

The Summer meeting of the Council was held at the Heart-o-Town Motor Inn in Charleston on Sunday, June 22, 1969, with the Chairman, Dr. Richard V. Lynch, Jr., of Morgantown, presiding.

Doctor Lynch introduced a new member of the Council, Dr. John J. Mahood of Bluefield, who was named to fill the unexpired term of Dr. W. Hampton St. Clair, Jr. He also introduced Mr. James S. Imboden of Columbus, Field Representative of the American Medical Association.

It was pointed out that during the past year the American Medical Association has been reexamining the Joint Commission on Accreditation of Hospitals. Earlier in the year a Subcommittee of the Committee on Medical Education and Hospitals of the State Medical Association was named to study the problem on the State level. The Chairman of the Subcommittee is Dr. Daniel Hamaty of Charleston and the other members are Doctors Lynch, Upshur Higginbotham of Bluefield, David Z. Morgan of Morgantown, George M. Kellas of Wheeling, and Grover B. Swoyer of Charleston.

It was reported that the Subcommittee will meet as frequently as necessary and will report to the Council through the parent Committee on Medical Education and Hospitals. It also was reported that Doctor Hamaty planned to contact the chiefs of staff of hospitals in the State, as well as the presidents of the component societies, in an attempt to enlist their support.

Resolution Concerning JCAH

There was considerable discussion concerning the new proposed standards for hospital accreditation currently under study by the Joint Commission. The following resolution was adopted unanimously and the two West Virginia Delegates were instructed to introduce the resolution at the 1969 Annual Meeting of the American Medical Association in New York City:

> WHEREAS, The American Medical Association is deeply concerned with the present trends in thought and action involved in recommendations already made or in line for future consideration by the Joint Commission on Accreditation of Hospitals; and
>
> WHEREAS, Many members of the American Hospital Association have expressed the opinion that physicians should not be members of hospital governing boards; therefore be it
>
> RESOLVED, That it is the considered judgment of the House of Delegates of the American Medical Association that practicing staff physicians shall have active representation on the governing board of every hospital; and be it further
>
> RESOLVED, That it is the judgment of the House of Delegates that one or more staff physicians shall be elected by and to the governing board of each hospital from a list of nominees presented by the medical staff of each hospital.

Candidacy of Dr. C. A. Hoffman

During the meeting it was announced that Dr. Edward R. Annis of Florida had withdrawn as a candidate for the Board of Trustees of the American Medical Association. It also was announced that the West Virginia delegation would place in nomination the name of Dr. C. A. Hoffman of Huntington to succeed Doctor Annis. Previously, the officers announced they would nominate Doctor Hoffman for the office of Vice Speaker of the House of Delegates.

Election of Honorary Members

The following physicians were elected to honorary membership in the State Medical Association:

Physician	*Address*	*Society*
A. M. Price	Madison	Boone
Philip Johnson	Fairmont	Marion
Thomas H. Blake	St. Albans	Kanawha
Ward Wylie	Salt Sulphur Springs	Wyoming
Richard D. Gill	Wheeling	Ohio
William K. Kalbfleisch	Wheeling	Ohio

1969 Nominating Committee

The following physicians were elected to serve as members of the Nominating Committee during the Annual Meeting at The Greenbrier:

Dr. Harry S. Weeks, Jr., of Wheeling, Dr. George A. Curry of Morgantown, Dr. Robert W. Bess, Jr., Piedmont, Dr. Andrew J. Weaver of Clarksburg, Dr. Robert L. Chamberlain of Buckhannon and Dr. A. Thomas McCoy of Charleston.

Dr. Richard E. Flood of Weirton, the Junior-Councilor-at-Large, automatically will serve as Chairman of the Committee which will recommend its nominees to serve as officers of the Association during 1969-70.

Physician's Assistant Program

Dr. Hu C. Myers of Philippi presented a progress report on the Physician's Assistant Program which was established at Alderson-Broaddus College during the fall of 1968. He said that at present the enrollment is being limited to 36 young men and women in each entering class. He expressed appreciation to the Council and the physician members of the Advisory Committee for their support and cooperation.

Doctor Myers also said a special exhibit was being prepared for display at the Annual Meeting of the State Medical Association at The Greenbrier.

Third Party Programs

Doctor Weeks reported that he had met recently with Mr. Edwin F. Flowers, Commissioner of the Department of Welfare, for the purpose of discussing the various medical programs under the administration of the Department.

Doctor Callender reported that he and Dr. Theodore P. Mantz, Chairman of the Subcommittee on Workmen's Compensation, had met on April 2 with the new Commissioner of the Workmen's Compensation Fund, Mr. Fred L. Davis, Jr. He said the Commissioner planned a thorough review of the rules and regulations of the Fund and had sought the advice of the Association in this undertaking.

The following members of the Council were present:

Dr. Richard V. Lynch, Jr., of Morgantown, Chairman; Dr. Richard W. Corbitt of Parkersburg, President; Dr. Maynard P. Pride of Morgantown, President

Elect; Dr. George R. Callender, Jr., of Charleston, Vice President; Dr. Richard E. Flood of Weirton, Councilor -at-Large; and Dr. Seigle W. Parks of Charleston; Drs. Harry S. Weeks, Jr., of Wheeling; George A. Curry of Morgantown; S. Elizabeth McFetridge of Shepherdstown; Robert W. Bess of Piedmont; A. Kyle Bush of Philippi; Andrew J. Weaver, Clarksburg; R. L. Chamberlain of Buckhannon; William L. Neal of Huntington; A. Thomas McCoy of Charleston; William T. Lawson of Fairmont; John J. Mahood of Bluefield; Worthy W. McKinney of Beckley; and Harold Van Hoose of Man; and Mr. William H. Lively of Charleston, Executive Secretary; and Mr. Edward D. Hagan of Charleston, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor of *The Journal;* Dr. James S. Klumpp of Huntington, Parliamentarian; Mr. James S. Imboden of Columbus, Field Representative of the AMA; Dr. L. J. Pace of Princeton, Chairman of the Mental Health Committee; Dr. Hu C. Myers of Philippi; and Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Department of Mental Health.

Medical Technologists Society Elects Beckley Woman

Miss Thelma Wilson, M. T., of Beckley has been named President Elect of the American Society of Medical Technologists.

An employee of the Beckley Appalachian Regional Hospital, Miss Wilson will assume the presidency of the national organization next June. A graduate of Concord College, Miss Wilson did postgraduate work at the University of Virginia after which she was registered as a medical technologist.

Motion Picture Schedule

Dr. John J. Mahood of Bluefield, Chairman of the Scientific Motion Picture Program for the Annual Meeting at The Greenbrier, has announced the schedule of motion pictures which will be shown in Governor's Hall each morning prior to the general scientific sessions.

Thursday—"Modern Concepts of Epilepsy" and "The Obsolete Menopause."

Friday—"The Function of the Ear in Health and Disease" and "Stagnant Shock—Lillehei."

Saturday—"Coronary Occlusion" and "Silicone Implant for Impotence."

Charleston Physician Honored By Psychiatric Assn.

Dr. Grover C. Robertson of Charleston was honored recently by the American Psychiatric Association.

Doctor Robertson was presented with a certificate citing his "50 years of service to the Association and to the field of psychiatry." The presentation was made during the Association's Convocation of Fellows in Miami Beach on May 5.

Doctor Robertson received his M. D. degree from the old Kentucky School of Medicine in Louisville. He has been a member of the West Virginia State Medical Association for 60 years.

The average American pays less for life-saving, health-giving drugs than for recreation: less than one-fifth as much for drugs as for liquor and tobacco. Of each dollar of disposable income, the average American spends less than 1¢ for prescription drugs!

Dr. Richard W. Corbitt of Parkersburg (second from right), President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Kanawha Medical Society, which was held on June 10 in Charleston. Also pictured are (left to right): Dr. W. Alva Deardorff, Secretary-Treasurer of the Kanawha Medical Society; Dr. George V. Hamrick, Vice President; Miss Charlotte Corbitt, who accompanied her father to Charleston; and Dr. A. Thomas McCoy, President of the Kanawha Medical Society.

Woman's Auxiliary To Conduct 45th Annual Meeting

The Presidents of the Woman's Auxiliaries to the American and Southern Medical Associations will be guest speakers at the 45th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association this month.

The sessions will be held concurrently with the 102nd Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23.

Mrs. John M. Chenault

Mrs. Virgil R. Forester

Mrs. John A. B. Holt of Charleston, President of the State Auxiliary, will preside at the sessions. She announced that Mrs. John M. Chenault of Decatur, Alabama, President of the Woman's Auxiliary to the American Medical Association, and Mrs. Virgil Ray Forester of Oklahoma City, Oklahoma, President of the Woman's Auxiliary to the Southern Medical Association, would be guests of honor.

More than 200 physicians' wives are expected to register for the meeting.

Pre-Convention Meetings

Auxiliary members are cordially invited to attend the opening meeting of the State Medical Association's House of Delegates at 3 P. M. on Wednesday, August 20. The guest speaker at the House session will be Dr. Gerald D. Dorman of New York City, President of the American Medical Association.

Mrs. Holt will preside at the Auxiliary's Pre-Convention Board Meeting at 4 P. M. on Wednesday.

Formal Convention Opening

The Association has invited members of the Auxiliary to attend the formal opening of the 102nd Annual Meeting on Thursday morning, August 21, at 9 A. M. This session will feature an address by the Hon. Arch A. Moore, Jr., Governor of West Virginia.

Following Governor Moore's address, the Auxiliary will open its own convention in the Fillmore and Van Buren Rooms of The Greenbrier.

First Business Session

Mrs. Chenault will give the keynote address at the Auxiliary's First Business Session, which begins at 9:45 A. M. on Thursday. Also addressing the Auxiliary at that time will be Dr. Richard W. Corbitt of Parkersburg, President of the West Virginia State Medical Association.

Other business of the First Session will include introduction of convention chairmen; roll call of delegates, treasurer's report; in memoriam service; recommendations from the Pre-Convention Board Meeting; report of the Revisions Committee; first reading of the report of the Nominating Committee; election of the 1970 Nominating Committee; reports from officers and standing committee chairmen; and presentation of component auxiliary presidents by regional directors.

The Keynote Speaker

Mrs. Chenault became President of the Woman's Auxiliary to the AMA on April 22 following the death of Mrs. Clifton C. Long of Ozark, Arkansas. She was formally installed as President during the AMA Auxiliary meeting in New York City last month.

Mrs. Chenault is a graduate of the University of Alabama. Her husband is a member of the AMA House of Delegates and is Chairman of the Board of Censors of the Alabama Medical Association. They were married in 1941 and have five children.

Long active in Auxiliary and civic and community affairs, Mrs. Chenault has served the AMA Auxiliary as a National Director, Historian, Chairman of the By-Laws Committee, First Vice President and President Elect. She is a two-time President of her county auxiliary and also has served as Alabama state President and President of the Woman's Auxiliary to the Southern Medical Association.

Among her many other interests are the Daughters of the American Revolution; the Garden Club of Alabama; the Girl Scouts; the League of Women Voters; the Women's Chamber of Commerce; the PTA; and the County Mental Health Association.

Bridge Tournament

Members of the Woman's Auxiliary to the Tygart's Valley Medical Society will be hostesses for a bridge tournament to be held in the Trellis Lobby of The Greenbrier beginning at 2 P. M. on Thursday afternoon.

The Past Presidents' Breakfast will be held at 8 A. M. on Friday morning, August 22, with Mrs. Rupert W. Powell of Fairmont, Immediate Past President, presiding.

Second Business Session

The Auxiliary's Second Business Session will be held beginning at 9:45 A. M. on Friday. Mrs. Forester will be the principal speaker.

Business of the Second Session will include the second reading of the report of the Nominating Committee; reports of various convention committees; and the election and installation of officers.

Mrs. Chenault will preside at the installation of new officers. Mrs. Joe N. Jarrett of Oak Hill will succeed Mrs. Holt as President. Mrs. Holt will give her presidential report, and Mrs. Jarrett will give an inaugural address.

Mrs. Holt will present the President's Pin and Gavel to Mrs. Jarrett; and Mrs. Powell will present the Past President's Pin to Mrs. Holt.

Like Mrs. Chenault, Mrs. Forester has been active in Auxiliary and civic activities. She is a graduate of Oklahoma Baptist University and the University of Oklahoma. Her husband, a gastroenterologist, practices in Oklahoma City and serves as Associate Professor of Medicine at the University of Oklahoma Medical School.

Mrs. Forester is a Past President of the Woman's Auxiliary to the Oklahoma County Medical Society and the Oklahoma State Medical Association. She also is active in the AMA Auxiliary in which she serves as a Director.

Friday Social Functions

Friday afternoon has been left free for golfing, with members of the Woman's Auxiliary to the Central West Virginia Medical Society serving as hostesses.

The Woman's Auxiliary to the Parkersburg Academy of Medicine will sponsor a "Topiary Garden Ball" beginning at 10 o'clock that evening in Chesapeake Hall.

Post Convention Board Meeting

The Post-Convention Conference and Board Meeting will be held at 10 A.M. on Saturday, August 23. Mrs. Jarrett will preside.

Saturday Afternoon Program

Members of the Auxiliary are cordially invited to attend the second and final session of the State Medical Association's House of Delegates on Saturday afternoon beginning at 2:30 o'clock. The session will feature the presidential address of Dr. Richard W. Corbitt of Parkersburg; the installation of Dr. Maynard P. Pride of Morgantown as President; and the election of other officers for the coming year.

Auxiliary members also are invited to attend a reception honoring the officers of the State Medical Association that evening. The function will be held on the Chesapeake Hall Terrace beginning at 6:30 P.M.

Convention Chairmen

Mrs. O. M. Harper of Clendenin is Chairman for the Auxiliary Convention, and Mrs. J. Dennis Kugel of Charleston is Co-Chairman.

Insurers Pay $500 Million For Part B Medicare

Private insurance companies paid out more than a half billion dollars in Part B Medicare benefits last year, according to the Health Insurance Institute.

The 15 companies which act as fiscal agents for the Federal government recorded a 20 per cent increase over total Part B benefit payments made to Americans 65 years and over a year earlier.

In making the Part B payments, the insurance companies processed over 11 million claims.

The Institute noted that the 15 insurance companies represented the government in all or part of 27 states and the Virgin Islands.

Mrs. John A. B. Holt
State Auxiliary President

The participating insurance companies are:

Aetna Life & Casualty, Connecticut General Life, Continental Casualty, Equitable Life Assurance Society, General American Life, John Hancock Mutual Life, and Metropolitan Life.

Also, Mutual of Omaha, Nationwide Mutual, Occidental Life, Pan-American Life, Pilot Life, Prudential, Travelers, and Union Mutual Life.

More Health Care Benefits Sought by Public

Consumer pressures for broader protection in the delivery and financing of health care benefits, coupled with increasing reliance on private enterprise to effectively implement government-sponsored health care programs, will fully test the capacities of the nation's 72 Blue Shield Plans.

Dr. Carl R. Ackerman, Chairman of the Board, National Association of Blue Shield Plans, made this assessment before a group of Blue Shield Plan directors and other executives. Private enterprise has furnished its expertise in other areas affecting the public interest—employment, housing, air and water pollution, rehabilitation—"the entire spectrum of socio-economic needs," the New York surgeon noted.

Blue Shield is "the specialist" in the financing of medical and surgical care, Doctor Ackerman said, and it must play an effective and meaningful role in the implementation of government-financed health care programs. If Blue Shield is to retain its position of leadership in the health care field, it must adapt to "a rapidly changing environment and new standards of benefits demanded by the American people."

Dr. A. C. Esposito to Present Eye Course in Chicago

The American Academy of Ophthalmology and Otolaryngology has invited Dr. Albert C. Esposito of Huntington to present a postgraduate course in ophthalmology at its annual convention in Chicago, October 12-16.

Albert C. Esposito, M. D.

Title of the course will be "Recent Advances in General Anesthesia, Local Anesthesia and Neuroloptic Analgesia in Cataract and Ocular Surgery: Preoperative and Postoperative Management."

Doctor Esposito, who was a member of the faculty of the Department of Ophthalmology, Ohio State University College of Medicine, before entering private practice in Huntington, is Secretary of the American Association of Ophthalmology. He has served as Chairman of the Section of Ophthalmology of the Southern Medical Association, and President of the West Virginia Academy of Ophthalmology and Otolaryngology.

He is a Past President of both the Cabell County Medical Society and the West Virginia State Medical Association. At the present time, he is First Vice President of the Southern Medical Association, an organization he has served as Councilor from West Virgniia and Chairman of the Council.

Doctor Esposito is the author of a number of scientific papers on ophthalmology which have been presented both in the United States and abroad.

Dr. Jack Basman Is Appointed To State Health Post

The appointment of Dr. Jack Basman of Charleston to head the Division of Maternal and Child Health of the State Health Department was announced recently by State Health Director N. H. Dyer.

Doctor Basman, a pediatrician, has been in private practice in Charleston for more than 30 years.

Two other Charleston pediatricians are now working as fulltime health staff executives. They are Drs. Harry Baldock and Mary Skinner.

Doctor Dyer said the addition of the three physicians to the department staff "will give us adequate leadership in this important field of health."

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Aug. 21-23—102nd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 2—Rural Health Conf., Jackson's Mill.
Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 20-21—W. Va. Hosp. Assn., White Sulphur Springs.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.
Oct. 31-Nov. 2—Pot.-Shen. Val. PG Inst., Martinsburg.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.

Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.

May 5-9—Am. Psychiatric Assn., San Francisco.
May 11-14—Am. Urological Assn., Philadelphia.
May 18-22—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.

June 21-25—AMA, Chicago.

CONVENTION PROGRAM

102nd Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS
August 21-23, 1969

WEDNESDAY MORNING

August 20

(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Richard V. Lynch, Jr., M. D., *presiding* (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

3:00—First Session of the House of Delegates. Richard W. Corbitt, M. D., *presiding* (Chesapeake Hall).

Invocation—Carl B. Hall, M. D.

Address: Gerald D. Dorman, President, American Medical Association.

Business Meeting.

THURSDAY MORNING

August 21

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall).

"Modern Concepts of Epilepsy" and "The Obsolete Menopause."

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—Jack J. Stark, M. D., *Chairman,* Program Committee.

Invocation—Tracy N. Spencer, Jr., M. D.

Address of Welcome—Richard W. Corbitt, M. D., President, West Virginia State Medical Association.

Address—Hon. Arch A. Moore, Jr., Governor of the State of West Virginia.

First General Session

Moderator: Seigle W. Parks, M. D.

9:45—Maj. Gen. Joe M. Blumberg (MC), Commanding General, United States Army Medical Research and Development Command, Washington, D. C. Subject: "Some Interesting or Unusual Cases in Forensic Pathology."

(Note: Immediately following the presentation of the paper, Doctor Blumberg will speak before a meeting of the West Virginia Association of Pathologists in the Mountaineer Room).

10:30—Recess for Visiting Exhibits.

11:00—Albert B. Ferguson, Jr., M. D., Professor and Chairman of the Department of Orthopedic Surgery at the University of Pittsburgh School of Medicine. Subject: "Degenerative Arthritis of the Hip—What It Is and the Modern Methods of Taking Care of It."

11:45—Francis M. Forster, M. D., Professor and Chairman of the Department of Neurology at the University of Wisconsin School of Medicine. Subject "Behavioral Treatment of Epilepsy —1969."

12:30—Recess for Lunch and Visiting Exhibits.

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. Richard V. Lynch, Jr., M. D., *presiding* (Tyler Room).

THURSDAY AFTERNOON

2:00—Resolutions Committee. Richard E. Flood, M. D., *presiding* (West Virginia Room).

2:00—Open Meeting, West Virginia State Society of Allergy. Grover C. Hedrick, M. D., *presiding* (Governor's Hall).

Moderator: Merle S. Scherr, M. D.

3:00—Seminar on "Insurance and Investments for Physicians." (Fillmore and Van Buren Rooms).

Moderator: C. A. Hoffman, M. D.

Guest Speakers: Edward R. Annis, M. D., Miami, Florida, President, The Denver Corporation.

Mr. E. H. Morgan, Hartford, Connecticut, Assistant Secretary, Underwriting Department in the Casualty and Surety Division of Aetna Life and Casualty Company.

Thomas S. Sexton, M. D., Springfield, Massachusetts, Senior Vice President of the Massachusetts Mutual Life Insurance Company.

Mr. J. Banks Shepherd, Charleston, President of McDonough - Caperton - Shepherd - Goldsmith Insurance Agency, and Administrator of the Group Insurance Program of the West Virginia State Medical Association.

6:00—Cocktail Party, University of Virginia Alumni Fund, Medical Division. James P. Baker, M. D., *in charge.*

6:30—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. Jean P. Cavender, M. D., *in charge* (Old White Club).

FRIDAY MORNING

August 22

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall).

"The Function of the Ear in Health and Disease" and "Stagnant Shock—Lillehei."

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: A. B. Curry Ellison, M. D.

9:30—Kermit E. Krantz, M. D., Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center. Subject: "The Placenta—Man's Best Friend."

10:15—Raymond J. Jackman, M. D., Head of the Section of Proctology at the Mayo Clinic, Rochester, Minnesota. Subject: "Crohn's Disease."

11:00—Recess for Visiting Exhibits.

11:30—Felix de la Cruz, M. D., Chief, Children's Diagnosis and Study Branch of the National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland. Subject: "Physicians' Role in Mental Retardation."

12:15—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. James T. Hughes, M. D., *presiding* (Governor's Hall).

Guest Speaker: Bruce C. Sinclair-Smith, M. D., Nashville. Subject: "Evaluation of Valvular Heart Disease."

2:00—Section on Pediatrics. Forest A. Cornwell, M. D., *presiding* (Mountaineer Room).

Guest Speaker: Felix de la Cruz, M. D., Bethesda, Maryland. Subject: "The High-Risk Infant."

Business Meeting.

2:00—Section on Urology. Harold N. Kagan, M. D., *presiding* (Director's Room).

Speaker: C. A. Hoffman, M. D., Huntington. Subject: "Socio-Economic Problems in Urology."

There also will be a Pyelographic Conference on Interesting Urological Cases.

Business Meeting.

2:00—Section on Surgery. Alvin L. Watne, M. D., *presiding* (Buchanan Room).

Guest Speakers: Raymond J. Jackman, M. D., Rochester, Minnesota. Subject: "Office Management of Anorectal Disease."

W. Glenn Young, Jr., M. D., Durham, North Carolina. Subject: "Surgery in Non-Tuberculous Pericarditis."

2:00—West Virginia Radiological Society. Andrew W. Goodwin, II, M. D., *presiding* (Pierce Room).

Guest Speaker: C. Douglas Maynard, M. D., Assistant Professor of Radiology, Bowman Gray School of Medicine, and Director of the Nuclear Medicine Laboratory at North Carolina Baptist Hospital, Winston-Salem. Subject: "The Uses of Radionuclides in the Evaluation of the Central Nervous System."

2:00—Section on Neurology, Neurosurgery and Psychiatry. Thomas J. Holbrook, M. D., *presiding* (West Virginia Room).

Guest Speaker: Francis M. Forster, M. D., Madison, Wisconsin. Subject: "Reading Epilepsy."

2:00—West Virginia Society of Anesthesiologists. E. Leon Linger, M. D., *presiding* (Jackson Room).

Guest Speaker: E. M. Papper, M. D., New York City. Subject: "The Transmission of Local Anesthetic Drugs from Mother to Fetus."

2:00—West Virginia Obstetrical and Gynecological Society. Robert Greco, M. D., *presiding* (Fillmore and Van Buren Rooms)

Guest Speaker: Kermit E. Krantz, M. D., Kansas City, Kansas. Subject: "Quo Vadis Femi-

nines?" or the "Changing Pattern of the American Woman."

2:00—Section on Orthopedic Surgery. John P. Griffith, Jr., M. D., *presiding* (Washington Room, West Virginia Wing).

Guest Speaker: Albert B. Ferguson, Jr., M. D., Pittsburgh. Subject: "Skeletal Trauma in Children."

2:00—West Virginia Academy of Ophthalmology and Otolaryngology. Edward Shupala, M. D., *presiding* (Lee Room, Virginia Wing).

Business Meeting.

3:30—West Virginia Chapter, American Society of Internal Medicine. R. U. Drinkard, M. D. *presiding* (Governor's Hall).

Business Meeting.

3:30—West Virginia District Branch, American Psychiatric Association. Roy A. Edwards, M. D., *presiding* (West Virginia Room).

5:00—Committee on Nominations. Richard E. Flood, M. D., *presiding* (Lee Room, Virginia Wing).

FRIDAY EVENING

10:00—Topiary Garden Ball sponsored by the Woman's Auxiliary (Chesapeake Hall).

SATURDAY MORNING

August 23

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall).

"Coronary Occlusion" and "Silicone Implant for Impotence."

9:00-2:00—Registration, Main Floor Lobby.

9:00—Ludwig Gutmann, M. D., Associate Professor and Acting Chairman, Department of Neurology, West Virginia University School of Medicine. Subject: "L-Dopa Therapy of Parkinson's Disease—A Review of the Preliminary Experience at West Virginia University."

"Symposium on Cardio-Respiratory Emergencies and Their Management"

Moderator: Herbert E. Warden, M. D.

9:30—E. M. Papper, M. D., Professor and Chairman of the Department of Anesthesiology, College of Physicians and Surgeons of Columbia University, New York City.

Bruce C. Sinclair-Smith, M. D., Associate Professor of Medicine, Vanderbilt University, Nashville, Tennessee.

W. Glenn Young, Jr., M. D., Professor of Surgery, Duke University School of Medicine, Durham, North Carolina.

Question and Answer Period (There will be a recess for visiting exhibits during the morning program).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates. Richard W. Corbitt, M. D., *presiding* (Chesapeake Hall).

Invocation: William E. Gilmore, M. D.

Presidential Address: Richard W. Corbitt, M. D., President, West Virginia State Medical Association.

Introduction of President of Woman's Auxiliary to the West Virginia State Medical Association.

Presentation of AMA-ERF check to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

Introduction of Honor Guests.

Business Meeting.

Election of Officers.

Installation of Maynard P. Pride, M. D., of Morgantown, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Dr. Francis M. Forster, Professor and Chairman of the Department of Neurology at the University of Wisconsin Medical Center, was born in Cincinnati.

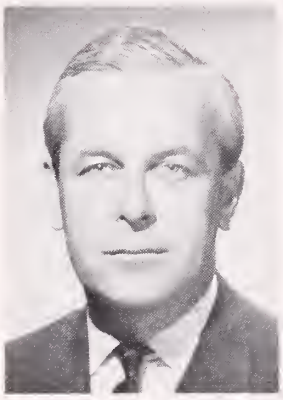
Francis M. Forster, M. D.

Doctor Forster received his M. D. degree in 1937 from the University of Cincinnati School of Medicine. He interned at Good Samaritan Hospital in Cincinnati and served as a House Officer in Neurology and Neurosurgery at Boston City Hospital. He served as a Fellow in Psychiatry at Pennsylvania Hospital and served a residency in neurology at Boston City Hospital.

He served one year as Assistant in Neurology at the Harvard Medical School and a year as Rockefeller Foundation Research Fellow in Physiology at Yale University School of Medicine. He served on the faculties of Boston University School of Medicine and Jefferson Medical College and was appointed in 1950 as Professor of Neurology and Director of the Department at Georgetown University School of Medicine.

In 1953 he was appointed Dean of the Georgetown University School of Medicine. Since 1958 he has held his present appointment.

A native of Australia, Dr. Bruce C. Sinclair-Smith is Associate Professor of Medicine at the Vanderbilt University School of Medicine.

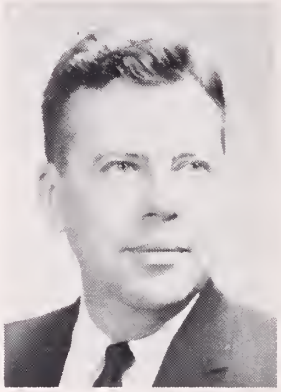


B. C. Sinclair-Smith, M. D.

Doctor Sinclair - Smith received M. B. and B. S. degrees from the University of Sydney. He served with the Royal Australian Army Medical Corps, 1944-47, as a Fellow at Johns Hopkins University Hospital in Baltimore, 1947-49, as a resident at the National Heart Hospital in London, 1949-51, and as a member of the faculty at the University of Sydney prior to joining the faculty at Vanderbilt.

He is a Fellow of the American College of Physicians, the Royal Australian College of Physicians and the Royal Edinburgh College of Physicians.

Mr. Edward H. Morgan is Assistant Secretary, Underwriting Department in the Casualty and Surety Division of Aetna Life and Casualty and Surety Company, Hartford, Connecticut. A graduate of Yale University,



Edward H. Morgan

Mr. Morgan joined the Company in 1935 and subsequently served as Assistant Underwriter, Underwriter and Supervisor. He was named Superintendent of Professional Liability Underwriting in 1961, a post he held until assuming his present position in May, 1965.

A former Instructor of Insurance at the University of Hartford, Mr. Morgan is a member of the General Liability and Professional Liability Rating Committees of the Insurance Rating Board. He is also a member of various committees of the Neuclear Energy Liability Insurance Association.

Mr. Morgan will participate in a Seminar on "Insurance and Investments for Physicians" which will be held on Thursday afternoon, August 21.

Dr. Edward R. Annis of Miami, Florida, President and Chief Executive Officer of the Denver Corporation, was born in Detroit.

Doctor Annis was graduated from the University of Detroit and received

Edward R. Annis, M. D.

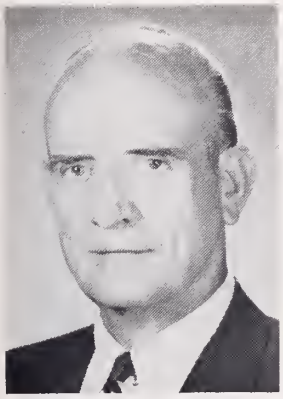
his M. D. degree in 1938 from Marquette University School of Medicine. He has served as Chief of the Department of Surgery at Mercy Hospital and Attending Physician at North Shore Hospital in Miami.

Doctor Annis has been active for many years in affairs of organized medicine and served a term as President of the American Medical Association, 1963-64. He also served as a member of the AMA Board of Trustees from 1967-69.

Doctor Annis, who has appeared as a speaker at three previous annual meetings, will participate in a Seminar on "Insurance and Investments for Physicians" which will be held on Thursday afternoon, August 21.

Mr. J. Banks Shepherd of Charleston, President of McDonough-Caperton-Shepherd-Goldsmith insurance firm, is a native of Raleigh County.

Mr. Shepherd received a degree in civil engineering from West Virginia University and attended the Harvard Graduate School of Business. His firm pioneered in the association group field and is now one of the largest administrators of association group programs in the country, serving as administrator of both state and national groups.



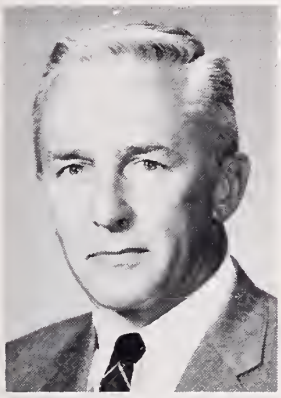
J. Banks Shepherd

Since 1948, Mr. Shepherd has served as Administrator of the Group Insurance Program of the West Virginia State Medical Association. He is currently serving as President of the American Institute of Professional Association Group Insurance Administrators.

He will participate in a Seminar on "Insurance and Investments for Physicians" which will be held on Thursday afternoon, August 21.

Dr. Albert B. Ferguson, Jr., Professor and Chairman of the Department of Orthopedic Surgery at the University of Pittsburgh School of Medicine, is a native of New York City.

Doctor Ferguson was graduated from Dartmouth College and received his M. D. degree in 1943 from Harvard Medical School. He interned at Children's Hospital and Peter Bent Brigham Hospital in Boston, and served residencies at those Hospitals as well as Massachusetts General Hospital. He served with the Medical Corps of the United States Marines, 1944-46.



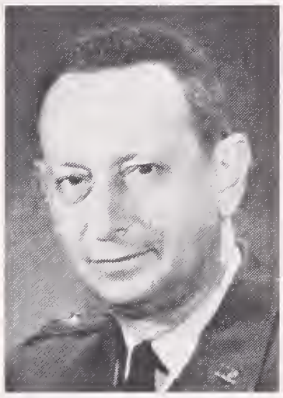
A. B. Ferguson, Jr., M. D.

He was a member of the faculty at Harvard Medical School prior to accepting his present position. Doctor Ferguson is certified by the American Board of Orthopedic Surgery and is a member of the American College of Surgeons. He is a member of the American Academy of Orthopedic Surgery, the American Orthopaedic Association, the American Association for Advancement of Science, and the New York Academy of Science.

He is a member of the Allegheny County Medical Society and the Pennsylvania Medical Society, and he serves as Orthopedic Surgeon for the Pittsburgh Pirates Baseball Club.

Maj. Gen. Joe M. Blumberg, MC, USA, Commanding General of the United States Army Medical Research and Development Command, is a native of Atlanta, Georgia.

General Blumberg received his M. D. degree in 1933 from Emory University School of Medicine. He interned at Maryland General Hospital in Baltimore and served a residency at Baltimore City Hospital. He practiced medicine and pathology in Baltimore from 1933 to 1941.



Maj. Gen. Joe M. Blumberg (MC)

He was commissioned in the United States Army Medical Corps Reserve in 1935 and was called to active duty in 1941. Some of his principal assignments included duty as Chief of the Laboratory Service at the Walter Reed Army Hospital, Commanding Officer and Chief of Pathology of the 406th Medical General Laboratory in Japan, and Consultant in Pathology and Laboratory Medicine to the Chief Surgeon of the Armed Forces in the Far East. Prior to being named to his present position in 1967, he served as Director of the Armed Forces Institute of Pathology.

General Blumberg is certified by the American Board of Pathology in anatomic pathology, clinical pathology and forensic pathology. He is a member of the American Society of Clinical Pathologists and the Southern Medical Association. He is currently serving as a member of the Board of Governors of the College of American Pathologists.

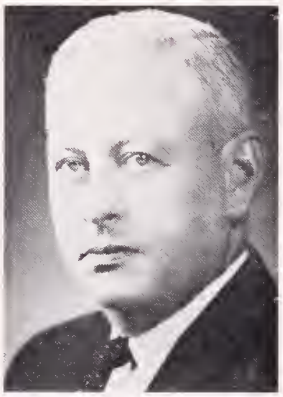
Dr. Raymond J. Jackman, Senior Consultant of the Section of Proctology at The Mayo Clinic in Rochester, Minnesota, was born in Emmetsburg, Iowa.

Doctor Jackman received his M. D. degree in 1930 from the University of Iowa School of Medicine. He interned at St. Mary's Hospital in Kansas City, Missouri, and served as a Fellow in Proctology at the Mayo Foundation. He received a Master of Science degree in 1938 from the University of Minnesota School of Medicine.

Raymond J. Jackman, M. D.

Doctor Jackman also serves as Professor of Proctology at the Mayo Graduate School of Medicine of the University of Minnesota School of Medicine. He is a member of the American Medical Association and is currently serving as President of the Minnesota State Board of Health.

Dr. Thomas S. Sexton, Senior Vice President of the Massachusetts Mutual Insurance Company, is a native of Sistersville, West Virginia. He was graduated from West Virginia University and received his M. D. degree from the University of Maryland School of Medicine.


Thomas S. Sexton, M. D.

He interned at Mercy Hospital in Baltimore and held a Fellowship in Internal Medicine at the Mayo Foundation for Medical Education and Research. During World War II, he served in Europe with the Medical Corps of the United States Army Air Force.

He joined the Medical Staff of the Massachusetts Mutual Insurance Company in 1947 and was appointed Assistant Medical Director that same year. He was named Medical Director in 1956, Vice President in charge of the new Business Division in 1959 and Vice President and Chief Medical Director in 1962. He was elected a member of the Board of Directors in 1965 and assumed his present position in 1968.

Doctor Sexton is President Elect of the Association of Life Insurance Medical Directors of America, and he holds membership in the Massachusetts Medical Society and the American Medical Association.

Doctor Sexton will participate in a Seminar on "Insurance and Investments for Physicians" which will be held on Thursday afternoon, August 21.

Dr. Kermit E. Krantz, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Kansas Medical Center, was born in Oak Park, Maryland.

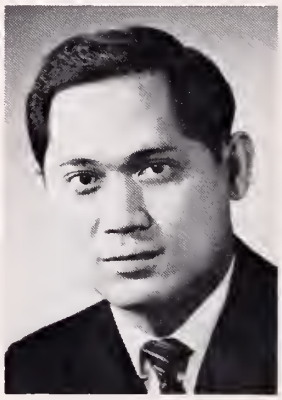
Kermit E. Krantz, M. D.

Doctor Krantz was graduated from Northwestern University and received his M. D. degree in 1948 from Northwestern University School of Medicine. He interned at New York Lying-In Hospital and served residencies at that Hospital, Cornell Medical College and Mary Fletcher Hospital in Burlington, Vermont.

He served on the faculties at the University of Vermont College of Medicine and the University of Arkansas School of Medicine prior to accepting his present position in 1959.

Doctor Krantz was certified in 1955 by the American Board of Obstetrics and Gynecology and he is a member of the American College of Surgeons and the American College of Obstetricians and Gynecologists.

Dr. Felix F. de la Cruz is Chief of the Children's Diagnostic and Study Branch, National Institute of Child Health and Human Development at the National Institute of Health in Bethesda, Maryland.


Felix F. de la Cruz, M. D.

A native of the Philippines, Doctor de la Cruz received his M. D. degree from the University of Santo Tomas in Manila. He received a Master of Public Health degree in 1961 from Johns Hopkins University School of Medicine.

He interned at the 6208th United States Air Force Hospital and served a residency at the University of Washington School of Medicine in Seattle. He served as a staff pediatrician at the Rainier School in Buckley, Washington, 1958-64, and was affiliated with Johns Hopkins University School of Medicine while on educational leave of absence from the Rainier School. He has been affiliated with the National Institutes of Health since 1964.

He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics and the American Association on Mental Deficiency.

Dr. W. Glenn Young, Jr., Professor of Surgery at the Duke University School of Medicine, was born in Washington, D. C.

Doctor Young was graduated from Duke University and received his M. D. degree in 1947 from the Duke University School of Medicine. He interned and served as a research fellow and resident in surgery at Duke University Hospital. He served with the Medical Corps of the United States Navy, 1950-1952.

W. Glenn Young, Jr., M. D.

He joined the faculty of the Duke University School of Medicine in 1955 and has been serving as Professor of Surgery since 1963.

Doctor Young is a Diplomate of the American Board of Surgery and Thoracic Surgery and is a member of Phi Beta Kappa. He is a member of the Society of University Surgeons, American Surgical Association, Society of Thoracic Surgeons and the American Federation for Clinical Research.

Gov. Arch A. Moore, Jr., of Glen Dale, served for 12 years in the U. S. House of Representatives before he was inaugurated as the 28th Governor of West Virginia last January.

Governor Moore was born in Moundsville and educated in the public schools of Marshall County. He was graduated from West Virginia University and received his Bachelor of Law (LL.B.) degree in 1951.

Gov. Arch A. Moore, Jr.

During World War II, Governor Moore served as a Combat Sergeant in the United States Army. He was the recipient of the Purple Heart as the result of severe wounds received on the battlefield.

Governor Moore was elected to the West Virginia House of Delegates in 1952 and in 1956 he was elected to the first of six consecutive terms in the United States Congress. During his service in Congress he became a ranking Republican member of the House Judiciary Committee and several other influential committees.

He is presently Republican National Committeeman from West Virginia and served as Chairman of the Sub-Committee in Charge of Rules and Procedures of the 1968 Republican National Convention.

He is married to the former Shelley Riley and they have three children.

Dr. Gerald D. Dorman of New York City was installed as President of the American Medical Association during the Annual Convention of the AMA in that city last month.

Doctor Dorman was born in Beirut, Lebanon, where his father, Dr. Harry Dorman, was Professor of Obstetrics and Dean of the School of Medicine at the American University of Beirut. He came to this country at the age of 17 and received a B. A. degree from Harvard in 1925.

Gerald D. Dorman, M. D.

He received his M. D. degree from Columbia University in 1929. After internship, Doctor Dorman was engaged in the practice of surgery until 1942, when he entered the Medical Corps of the U. S. Army as a field surgeon, serving with the Second Evacuation Hospital in Europe. He retired five years ago with the rank of Colonel in the U. S. Army Reserves.

Doctor Dorman is a Vice President and Medical Consultant for the New York Life Insurance Company. He was an AMA delegate from the Medical Society of the State of New York for six years until he was elected to the AMA Board of Trustees in 1960.

In 1966, he became Secretary-Treasurer of the AMA and Secretary of the Board of Trustees.

Doctor Dorman is a member of many professional, business and public service organizations. He is a Fellow of the American Geriatric Society and the Industrial Medical Association, a Diplomate of the Board of Preventive Medicine and Occupational Medicine, and Chairman of the Council of the World Medical Association.

Doctor Dorman was married to the former Georgia Foster White, who died in 1960, and they had two children and seven grandchildren. In March of 1962, he married the former Lois Ackerman.

Dr. Emanuel M. Papper, Professor and Chairman of the Department of Anesthesiology at the College of Physicians and Surgeons of Columbia University, is a native of New York City.

Doctor Papper was graduated from Columbia University and received his M. D. degree in 1938 from New York University School of Medicine. He interned and served residencies at Bellevue Hospital and served as a Fellow in Physiology at New York University. He was a member of the faculty at New York University prior to accepting his present position in 1949.

Emanuel M. Papper, M. D.

He served as a Major in the Medical Corps of the United States Army, 1942-46, and was Chief of the Section on Anesthesiology at Torney Dibble and Walter Reed Hospitals.

Doctor Papper was certified in 1943 by the American Board of Anesthesiology and served as President of the Board, 1964-65. He is a Past President of the American Society of Anesthesiologists and a member of the American College of Anesthesiologists, American College of Physicians and the Association of University Anesthetists.

He is the author of two books and has contributed more than 175 scientific articles to professional journals.

Dr. Ludwig Gutmann, Associate Professor and Acting Chairman, Department of Neurology, West Virginia University School of Medicine, was graduated from Princeton University and received his M. D. degree in 1959 from the College of Physicians and Surgeons of Columbia University.

Ludwig Gutmann, M. D.

He interned at the University of Wisconsin Medical Center, 1959-60, and served a residency at the same Medical Center from 1960 to 1963. He served as Chief of the Neurology Service, USAF Hospital, Scott Air Force Base, Illinois, 1963-65. He also served as a Neurological Consultant at Alton State Hospital in Alton, Illinois, during the same period.

He served as a Fellow in Neurophysiology at the Mayo Clinic in Rochester, Minnesota, 1965-66. He was named Assistant Professor of Neurology at the WVU School of Medicine in 1966 and also has been serving as Assistant Professor in the Department of Physiology and Biophysics for the past year. He assumed his present position on July 1.

Dr. C. Douglas Maynard, Assistant Professor of Radiology at the Bowman Gray School of Medicine, and Director of the Nuclear Medicine Laboratory at North Carolina Baptist Hospital in Winston-Salem, is a native of Atlantic City, New Jersey.

C. Douglas Maynard, M. D.

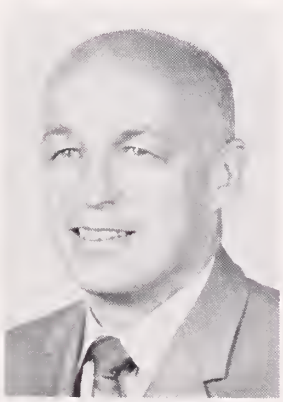
He was graduated from Wake Forest University and received his M. D. degree in 1959 from the Bowman Gray School of Medicine. He interned at Tripler United States Army Hospital in Honolulu, Hawaii, 1959-60, and served a residency at North Carolina Baptist Hospital, 1963-66.

He was engaged in general practice in Fayetteville, North Carolina, 1962-63, and was an American Cancer Fellow, 1964-65. He joined the faculty of the Bowman Gray School of Medicine in 1967 and he is a member of the American Medical Association and the Society of Nuclear Medicine. He has contributed numerous articles to scientific journals.

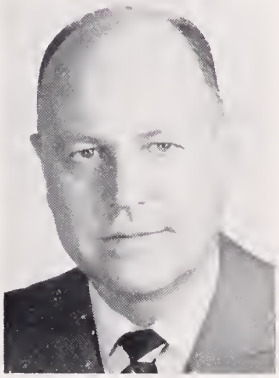
1969 PROGRAM COMMITTEE

Seigle W. Parks, M. D.
Charleston

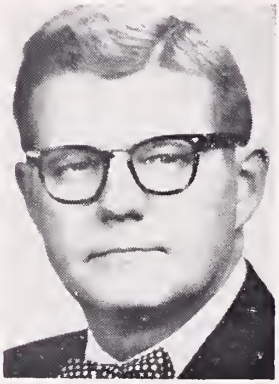
A. B. Curry Ellison, M. D.
Charleston



Jack J. Stark, M. D.
Parkersburg
Chairman



I. Ewen Taylor, M. D.
Huntington



Herbert E. Warden, M. D.
Morgantown

DELEGATES AND ALTERNATES

BOONE (2)—Delegates, H. H. Howell, Madison; and W. V. Wilkerson, Whitesville. Alternates, David E. Wallace and A. E. Glover, Madison.

BROOKE (2)—Delegates, Ralph McGraw, Follansbee; and W. T. Booher, Sr., Wellsburg. Alternates, John W. Traubert, Wellsburg; and James E. Wise, Follansbee.

CABELL (10)—Delegates, Salvador Diaz, Roy A. Edwards, Jr., Harold N. Kagan, John F. Otto, Jr., Joseph E. Ricketts, Thomas F. Scott, Elmer T. Vega, Frank M. Peck, W. L. Neal and C. A. Hoffman, Huntington. Alternates, Jack H. Baur, C. Stafford Clay, Hans W. Dransfeld, Jack Leckie, M. Bruce Martin, Thomas W. Nale, Charles M. Polan, Wilson P. Smith, Sarah L. C. Stevens and I. Ewen Taylor, Huntington.

CENTRAL WEST VIRGINIA (4)—Delegates, Joseph B. Reed, Rigoberto Ramirez and J. C. Huffman, Buckhannon; and Louis W. Groves, Jr., Richwood. Alternates, R. L. Chamberlain, Buckhannon; and C. R. Davisson, Weston.

EASTERN PANHANDLE (4)—Delegates, Halvard Wanger and S. Elizabeth McFetridge, Shepherdstown; and Leo H. T. Bernstein and R. R. Pittman, Martinsburg. Alternates, Frank J. Gavlas and Jean P. Lucas, Martinsburg; and William P. Wanger, Charles Town.

FAYETTE (2)—Delegates, W. P. Bittinger, Oak Hill; and T. Kerr Laird, Montgomery. Alternates, Thomas C. Sims, Longacre; and Joe N. Jarrett, Oak Hill.

GREENBRIER VALLEY (3)—Delegates, G. S. Julias, James P. Baker and Harvey A. Martin, White Sulphur Springs. Alternates, Eugene J. Morhous, White Sulphur Springs; Paul E. Prillaman, Jr., Ronceverte; and Luther E. Rexrode, Marlinton.

HANCOCK (3)—Delegates, Richard E. Flood, Ray S. Greco and J. L. Thompson, Weirton. Alternates, Myer Bogarad, T. R. Whitaker and Dominic A. Brancazio, Weirton.

HARRISON (4)—Delegates, Robert D. Hess, Bridgeport; L. Dale Simmons, Hugh M. Brown, and Joseph Gilman, Clarksburg. Alternates, Paul E. Gordon, A. Robert Marks, Andrew J. Weaver, and Charles S. Harrison, Clarksburg.

KANAWHA (16)—Delegates, Marshall J. Carper, Jean P. Cavender, W. Alva Deardorff, Charleston; Leonard M. Eckmann, South Charleston; A. B. Curry Ellison, Carl B. Hall, George V. Hamrick, John M. Hartman, Charleston; George W. Hogshead, Nitro; E. Q. Hull, South Charleston; and James W. Lane, Milton J. Lilly, A. Thomas McCoy, Page H. Seekford, G. A. Shawkey and Pat A. Tuckwiller, Charleston. Alternates, A. A. Abplanalp, Charleston; R. S. Birckhead, Gauley Bridge; Robert C. Bock, Charles D. Cottrell, Robert A. Crawford, Charleston; Donald E. Cunningham, St. Albans; Willis D. Garrard, Charleston; Ralph J. Holloway, South Charleston; John A. B. Holt, Charleston; James S. Kessel, Ripley; J. Dennis Kugel, Richard A. Lewis, Jimmie L. Mangus, William B. Rossman, Charleston; Joseph A. Smith, Dunbar; and Charles E. Staats, Charleston.

LOGAN (3)—Delegates, Sergio A. Payuyo, Logan; and Thomas P. Long and Harold Van Hoose, Man. Alternates, Ray M. Kessel, Abraham Tow and Mark Spurlock, Logan.

MARION (4)—Delegates, G. Thomas Evans, Fairmont; R. R. Frye, Mannington; and F. W. Mallamo and Rupert W. Powell, Fairmont. Alternates, William T. Lawson, Joseph T. Mallamo, Jack C. Morgan and Joseph D. Romino, Fairmont.

MARSHALL (2)—Delegates, Kenneth J. Allen, Moundsville; and Andrew J. Barger, Glen Dale. Alternates, Wm. Paul Bradford, Moundsville; and David E. Yoho, Glen Dale.

MASON (2)—Delegates, John M. Grubb and Aarom Boonsue, Pt. Pleasant.

McDOWELL (3)—Delegates, Ray E. Burger, A. J. Villani and Joseph C. Ray, Welch. Alternates, Robert W. Hansen, Welch; John H. Murry, Gary; and A. A. Carr, Welch.

MERCER (5)—Delegates, Henry F. Warden, Jr., Upshur Higginbotham, Sam Milchin, John J. Mahood and William M. Bruch, Bluefield. Alternates, David F. Bell, Jr., Bluefield; Joe E. McCary and Jess P. Champion, Princeton; and David M. Wayne and Richard O. Rogers, Jr., Bluefield.

MINGO (2)—Delegates, Robert J. Tchou and Paul E. Walker, Williamson. Alternates, Arthur E. Levy and Rodrigo V. de Valle, Williamson.

MONONGALIA (6)—Delegates, Lawrance S. Miller, George A. Curry, I. A. Wiles, Robert J. Fleming, James Hugh Wiley and French R. Miller, Morgantown. Alternates, Arthur W. Kelley, Hubert A. Shaffer, Margaret I. Stemple and David Z. Morgan, Morgantown.

OHIO (8)—Delegates, Robert R. Weiler, Harry S. Weeks, Jr., R. U. Drinkard, E. Lee Jones, Thomas L. Thomas, Stephen D. Ward, Wm. E. McNamara and Herbert G. Dickie, Jr., Wheeling. Alternates, Wendell M. Burns, William R. Barton, J. A. Jacob, Nime K. Joseph, J. N. Aceto, Milton E. Nugent, Alfred D. Ghaphery and M. D. Reiter, Wheeling.

PARKERSBURG ACADEMY (6)—Delegates, James C. Batten, Robert C. Lincicome, S. William Goff, William E. Gilmore and Charles H. Barnett, Parkersburg. Alternates, Robert D. Crooks and Richard Hamilton, Parkersburg; Martha J. Coyner, Harrisville; and James M. Carter and Dwight P. Cruikshank, Parkersburg.

POTOMAC VALLEY (3)—Delegates, V. L. Dyer, Petersburg; J. H. Wolverton, Jr., and Robert W. Bess, Jr., Piedmont. Alternates, Harry F. Coffman, Keyser; Charles J. Sites, Franklin; and Robert W. McCoy, Jr., Keyser.

PRESTON (2)—Delegates, Del Roy R. Davis and Donald P. Brown, Kingwood. Alternates, William H. Harriman, Jr., Terra Alta; and James V. Gainer, Jr., Kingwood.

RALEIGH (5)—Delegates, B. B. Richmond, Forest A. Cornwell, Walter E. Klingensmith, Worthy W. McKinney and John M. Daniel, Beckley. Alternates, C. Richard Daniel, Grover C. Hedrick, Jr., Charles W. Merritt, Richard G. Starr and George A. Miller, Beckley.

SUMMERS (2)—Delegates, Buford W. McNeer and Jack D. Woodrum, Hinton. Alternates, A. W. Holmes and Davis Wm. Ritter, Hinton.

TYGART'S VALLEY (4)—Delegates, Charles L. Leonard, Elkins; Samuel J. Bucher, Harman; and A. Kyle Bush, Philippi. Alternates, Raymond W. Cronlund, Philippi; E. E. Hutton, Jr., Elkins; and Karl J. Myers, Philippi.

WETZEL (2)—Delegates, Lemoyne Coffield and Charles P. Watson, New Martinsville. Alternates, Terrell Coffield, New Martinsville; and Allen M. Dyer, Jr., Pine Grove.

WYOMING (2)—Delegates, Ernest Poral and Ross E. Newman, Mullens.

Reception Committee

James S. Klumpp, *Chairman*

Harry S. Weeks, Jr.
Stephen D. Ward
Jack J. Stark
C. A. Hoffman

A. B. Curry Ellison
Forest A. Cornwell
Meryleen B. Smith
W. Gene Klingberg

Frank J. Holroyd
Richard E. Flood
Thomas G. Reed
Thomas J. Holbrook

Barbara Jones
E. L. Linger
Allen E. Yeakel
Norman W. B. Craythorne

Charles C. Weise
Florence K. Hoback
Roy A. Edwards, Jr.
John P. Griffith, Jr.

Peter Chang
James T. Hughes
David Z. Morgan
Richard G. Starr

William R. Barton
Nicholas D. Zambos
L. Walter Fix
C. R. Chamberlain, Jr.

D. Sheffer Clark
Herbert E. Warden
S. William Goff
L. J. Pace

Dennis S. O'Connor
Robert Greco
Warren D. Elliott
A. J. Villani

K. G. MacDonald
J. C. Huffman
A. Thomas McCoy
Richard W. Corbitt

John T. Chambers
Alvin L. Watne
Bernard Zimmermann
William E. Gilmore

A. C. Esposito
Seigle W. Parks
Maynard P. Pride
Richard V. Lynch, Jr.

Official Program
WOMAN'S AUXILIARY
to the
West Virginia State Medical Association
45th Annual Meeting
THE GREENBRIER
White Sulphur Springs
August 21-23, 1969

WEDNESDAY
August 20

3:00—First Session of the House of Delegates, State Medical Association (Chesapeake Hall).

Address: Gerald D. Dorman, M. D., President of the American Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

4:00—Pre-Convention Board Meeting. Mrs. John A. B. Holt, President, *presiding* (Fillmore and Van Buren Rooms).

THURSDAY MORNING
August 21

9:00—Formal Opening of the 102nd Annual Meeting of the West Virginia State Medical Association (Governor's Hall).

Address by the Hon. Arch A. Moore, Jr., Governor of West Virginia. (Auxiliary Members are Invited and Urged to Attend).

9:45—Formal Opening of the Convention, Mrs. John A. B. Holt, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation and Pledge of Loyalty.

Welcome.

Response.

Introduction of Honor Guests.

Presentation of Richard W. Corbitt, M. D., President, West Virginia State Medical Association.

Introduction of Convention Chairmen, Mrs. O. M. Harper and Mrs. J. Dennis Kugel.

Roll Call of Delegates.

Convention Rules of Order.

Treasurer's Report.

In Memoriam.

Credentials and Registration.

Keynote Address—Mrs. John M. Chenault, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting.

New Business and Announcements.

Report of the Revisions Committee.

Report of the Nominating Committee, First Reading.

Election of the 1970 Nominating Committee.

Reports from Officers and Standing Committee Chairmen.

Presentation of Component Auxiliary Presidents by the Regional Directors:

Eastern Region, Mrs. Charles E. Andrews.

Northern Region, Mrs. Herbert G. Dickie, Jr.

Western Region, Mrs. Joseph E. Ricketts.

Southern Region, Mrs. J. Elliott Blaydes, Jr.

THURSDAY AFTERNOON

2:00—Bridge (Trellis Lobby) Tygart's Valley Auxiliary.

FRIDAY MORNING
August 22

8:00—Past President's Breakfast, Mrs. Rupert W. Powell, Immediate Past President, *presiding*.

9:45—Second General Session, Mrs. John A. B. Holt, President, *presiding* (Fillmore and Van Buren Rooms).

Introduction of Guests.

Address—Mrs. Virgil Ray Forester, President, Woman's Auxiliary to the Southern Medical Association.

Report of the Reading Committee.

Convention Announcements.

Reports of Convention Committees:

Finance.

Courtesy Resolutions.

Credentials and Registration.

Press and Publicity.

Report of the Nominating Committee, Second Reading.

Election of Officers.

Report of the President.

Installation of Officers, Mrs. John M. Chenault, President of the Woman's Auxiliary to the American Medical Association.

Presentation of the President's Pin and Gavel.

Presentation of the Past President's Pin.

Inaugural Address—Mrs. Joe N. Jarrett.

Announcements.

Adjournment.

FRIDAY AFTERNOON

2:00—Golf, Central West Virginia Auxiliary.

FRIDAY EVENING

10:00 P. M. to 1:00 A. M.—"A Topiary Garden Ball" —Arranged by the Woman's Auxiliary to the Parkersburg Academy of Medicine.

SATURDAY MORNING

August 23

10:00—Post-Convention Conference and Board Meeting, Mrs. Joe N. Jarrett, President, *presiding* (Fillmore and Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates of the State Medical Association (Chesapeake Hall).

Presidential Address by Richard W. Corbitt, M. D., President of the West Virginia State Medical Association.

Installation of Dr. Maynard P. Pride as President of the West Virginia State Medical Association. (Auxiliary Members are Invited and Urged to Attend).

SATURDAY EVENING

6:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

REGISTRATION—MAIN LOBBY

Wednesday, August 20	3-5 P. M.
Thursday, August 21	8 A. M. - 4 P. M.
Friday, August 22	8 A. M. - 1 P. M.

Please register early and secure badge and program!

No registration fee will be assessed against members or guests in connection with the 45th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-23, 1969.

SCIENTIFIC EXHIBITS

SOCIAL SECURITY ADMINISTRATION

"SOCIAL SECURITY AND REHABILITATION"—This is a colorful single panel exhibit prepared by the Social Security Administration outlining how the Social Security Disability Program helps encourage applicants for disability benefits to undertake rehabilitation. The exhibit invites attention to a number of incentives built into the Disability Program to ease the worries of a disabled person seeking to return to work.

William S. Herold, M. D., Medical Consultant, and Mr. James Swaim, Field Representative.

AMERICAN MEDICAL ASSOCIATION
(Department of Mental Health)

"TREATING ALCOHOLISM"—This exhibit presents an overview of general medical and psychiatric considerations in the treatment of alcoholism. Major treatment aspects related to CNS disorders and liver ailments are summarized, and principles of individual and group psychotherapy, as well as of medication and specialized techniques, are delineated.

Mrs. Rose Roach, Chicago.

AMERICAN CANCER SOCIETY
(West Virginia Division, Inc.)

"CHILDHOOD CANCER"—This exhibit presents the problem of childhood cancer and the value of early diagnosis and proper treatment. It emphasizes the methods of treatment and the results which can be obtained in the most common forms of cancer in children, namely, nephroblastoma (Wilms' Tumor), neuroblastoma and soft-part sarcomas. The misconceptions which some physicians have concerning childhood cancer are covered.

William A. Nichols, Executive Vice President.

WEST VIRGINIA HEART ASSOCIATION

"COMMON CARDIAC ARRHYTHMIAS"—The West Virginia Heart Association Professional Education exhibit is designed to give the physician an opportunity to simultaneously see and hear a discussion of common cardiac arrhythmias. The arrhythmia patterns will be presented on audio-visual tape with oscilliscope screening for physician viewing. There also will be audio-visual tapes available on the not so common arrhythmia, for those who wish to take advantage of them. The exhibit has been prepared by D. Sheffer Clark, M. D., and Cabell-Huntington Hospital.

Mr. Richard J. Bates, Executive Director, and Mrs. Jenny Harris, Program Director.

WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION

Produced by the Rehabilitation Services Administration in Washington, D. C., this four-panel exhibit features color transparencies for illustration and is topped with a rotating circular fixture using the theme, "Help for the Disabled Through Vocational Rehabilitation." The panels, each illustrating a different phase of rehabilitation, explain the basic services offered by the Division of Vocational Rehabilitation, the role of the Rehabilitation Services Administration, the advantages of choosing a career in vocational rehabilitation, and how a client may apply for services with the agency.

Mr. Thorold S. Funk, Director, and William S. Herold, M. D., Chief Medical Consultant.

WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

"OFFICE MANAGEMENT OF CHRONIC OBSTRUCTIVE LUNG DISEASE"—The exhibit will present, through the use of a short film clip and several tables, the elements of rational office management of emphysema and chronic bronchitis. These will include: the clinical characteristics of obstructive respiratory syndromes, pertinent observations for office visits, basic principles of management, and indications for hospitalization. Reprints of an article on the subject by Dr. John A. Pierce, Director, Division of Pulmonary Diseases, Washington University School of Medicine, which was published in our quarterly journal, *Clinical Notes on Respiratory Diseases,* will be available as a "take-home" item.

Mr. Thomas A. Deveny, Jr., Executive Director.

CHESAPEAKE & OHIO RAILWAY CO.
BALTIMORE & OHIO RAILROAD CO.
(Medical Department)

This display traces the history of Railroad Medicine from 1834, when the country's first railroad physician was employed. The focal point is a full-size replica of the horse-drawn "PIONEER," first railroad passenger car used in revenue service—the first to which a physician was assigned for the convenience of passengers. It contrasts railroad medicine in the horse and carriage era with its ultramodern medical techniques and procedures, including use of computers and long distance telephonic transmission of electrocardiographic tracings.

I. Kaplan, M. D., Medical and Surgical Director.

ALDERSON-BROADDUS COLLEGE BROADDUS HOSPITAL AND THE MYERS CLINIC

The Physician's Assistant Program of Alderson-Broaddus College was developed in response to an increasing need for qualified assistants by doctors. The advice of many leaders in medical education was sought and followed. A job description was developed, after which a curriculum committee programmed didactic courses and a clinical experience sequence which should prepare a graduate to do the various proposed tasks. The four-year program leads to a Bachelor of Science degree with a major in medical science. The exhibit will show some of the major areas in which an assistant is being trained to help a physician.

Hu C. Myers, M. D., Mrs. Avanelle W. Myers and Mr. J. Richard Crawford.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

This exhibit describes, in a fairly basic way, the diagnosis and treatment of rheumatoid arthritis. Both surgical and non-surgical treatments are shown. We have used the wrist and knee as our representative joints and have demonstrated non-surgical bracing and splinting as well as photographs and x-rays of wrists and knees before, during and after synovectomy, tendon transposition, arthrodesis, osteotomy and arthoplasty. Basic details of surgical techniques are outlined.

William R. Murray, M. D., San Francisco.

THE NATIONAL FOUNDATION MARCH OF DIMES

"CHEMISTRY, CHROMOSOMES AND CONGENITAL ANOMALIES"—This exhibit presents by means of models, diagrams and pictures the suggested relationship between deoxyribonucleic acid in chromosomes, as inferred from bacterial genetics, and the relationship between abnormal chromosome patterns and congenital anomalies.

Mr. G. William Trout, State Representative; and Mrs. Charles Frick, Regional Volunteer Advisor.

THE CLEVELAND CLINIC FOUNDATION

"PORTAL HYPERTENSION—THE SELECTION OF PATIENTS FOR PORTAL-SYSTEMIC SHUNT"—This exhibit outlines the value of certain preoperative studies in patients with portal hypertension complicated by bleeding from esophageal varices or medically intractable ascites, prior to the selection of patients for portal-systemic shunt. Those factors associated with increased risk in the surgery of portal hypertension are identified and emphasis is placed on selecting patients for surgery to obtain the lowest morbidity and mortality.

Robert E. Hermann, M. D., A. E. Rodriguez, M. D., B. H. Sullivan, Jr., M. D., C. H. Brown, M. D., and L. J. McCormack, M. D.

MANAGEMENT OF LEG CRAMPS OF PERIPHERAL VASCULAR DISORDERS

A common complaint of geriatric patients with peripheral vascular ischemia is painful cramping of leg muscles, either of the intermittent claudication or nocturnal leg cramp variety. Papaverine selectively relaxes smooth muscles, which relaxation appears to be more prominent if spasm exists; however, the muscle cell is not paralyzed and still responds to drugs and vasomotor stimuli. The effectiveness of papaverine Hcl (sustained release form) was studied in three double-blind cross-over programs involving 25 to 30 geriatric patients presenting diverse vascular disturbances. Two programs involved patients presenting diabetes mellitus also.

Francis H. Stern, M. D., Philadelphia.

AMERICAN GERIATRICS SOCIETY, INC.

"ADEQUATE MEDICAL CARE FOR THE AGED"—There are 19 million Americans age 65 and over, and this is increasing by 1,000 persons every 24 hours. Aging people are afflicted with special mental and physical health problems. Insufficient numbers of health professionals are trained in geriatrics. Research is needed to make the increasing life span of man both productive and enjoyable, thereby assuring the right of the aged to live in dignity.

F. P. Rhoades, M. D., Detroit, Director.

NATIONWIDE INSURANCE COMPANY

"PART B CARRIER'S ROLE IN MEDICARE" is briefly described in the display. The booth will be in the charge of Mr. R. E. Lenhart, Medicare Manager of West Virginia, and other experienced Nationwide Medicare personnel will be available to answer general and specific Medicare inquiries during convention exhibit hours.

R. E. Lenhart, West Virginia Medicare Manager.

SOUTHERN MEDICAL ASSOCIATION

This exhibit describes the educational features supported by the Southern Medical Association, such as *The Journal* and the Annual Meeting. It also points out the advantages of membership in the SMA.

Mrs. Martha D. Hooks, Administrative Assistant.

HERBERT J. THOMAS HOSPITAL
South Charleston, West Virginia

"CLINICAL USE OF THE SCINTILLATION CAMERA"—One thousand scans in the past 18 months have proven the scintillation camera to be of value in the diagnosis and demonstration of disease, in some cases disease that cannot otherwise be demonstrated. The camera has proved to be of greatest value with brain scanning.

W. Alva Deardorff, M. D., Department of Radiology.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

This display depicts services to alcoholics and their families offered by the Division of Alcoholism, West Virginia Department of Mental Health. It outlines the dimensions of the alcoholism problem in the State and emphasizes the services available through community-based Alcoholism Information Centers, where specialized personnel offer counseling, guidance and referral, as well as intensive treatment for alcoholics provided in some of the State's mental hospitals.

Mildred M. Bateman, M. D., Director.

WEST VIRGINIA DEPARTMENT OF HEALTH
(Vaccination Program)

The portable, tabletop exhibit of the West Virginia State Health Department's Vaccination Program consists of three back-lighted panels of photographic illustrations. The first two panels depict some of the motivational approaches and clinic activities of our campaign. The third panel points up the success of the program with a graph showing the dramatic decline of measles in West Virginia and the United States during 1963-69.

Mr. Arthur Schultz, Program Coordinator.

INDUSTRIAL EXHIBITS

AMERICAN MEDICAL BUILDING GUILD
Madison, Wisconsin

Booth 7

APACHE CORPORATION
Minneapolis, Minnesota

Booth 24

AUTOMATED MANAGEMENT SYSTEMS
Paden City, West Virginia

Booth 10

AYERST LABORATORIES
New York City, New York

Booth 25

Ayerst Laboratories extends an invitation to visit our exhibit located in Booth 25 where Premarin® and Atromid-S® are being featured. Our representatives will be pleased to discuss these or other Ayerst products with you.

BRISTOL LABORATORIES
Syracuse, New York

Booth 18

Representatives: Mr. Jack Burford, Mr. Bill Dawson, and Mr. Upshur Higginbotham, Jr.

THE COCA-COLA COMPANY
Atlanta, Georgia

Booth 42

Ice cold Coca-Cola served through the courtesy and cooperation of The Coca-Cola Bottling Company of Clifton Forge, Virginia, and The Coca-Cola Company.

CIBA PHARMACEUTICAL CO.
Summit, New Jersey

Booth 8

THE DENVER CORPORATION
Washington, D. C.

Booth 5

ELI LILLY AND COMPANY
Indianapolis, Indiana

Booth 43

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance will welcome your questions about Lilly pharmaceutical products. You may be particularly interested in discussing Ilosone® Erythromycin Estolate.

Representatives: Mr. R. D. Morr and Mr. Frank Adams.

ENDO LABORATORIES, INC.
Garden City, New York

Booth 16

Endo Laboratories will present the latest clinical information relating to our products, Coumadin® (Warfarin Sodium), Numorphan® (Oxymorphone) HCL, Percodan®, Percodan®-Demi, Hycomine®, Hycomine®-Compound, Hycodan®, Valpin® (Anisotropine Methylbromide), Valpin®-PB (Anisotropine Methylbromide with Phenobarbital), Percogesic®, Percogesic®-C., Hycomine®-Pediatric.

FEICK BROTHERS CO.
Pittsburgh, Pennsylvania

Booth 32

Representatives: Mrs. Genevieve Sauers and Mr. Barnie Morisey.

HOSPITAL AND PHYSICIANS SUPPLY CO.
Charleston, West Virginia

Booth 45

MALKIN INSTRUMENT CO.
Louisville, Kentucky

Booth 19

We will have on display Mennen-Greatbatch monitoring equipment, Cambridge EKG machines and Medtronic pacemakers.

Representatives: Mr. George Reeser and Mr. Gary Fullerton.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about Oracon, Enfamil, and Gynorest.

Representatives: Mr. Charles E. Derbyshire, Mr. John H. Crowell, and Mr. Fred Pyles.

THE MEDICAL ARTS SUPPLY COMPANY
Huntington, West Virginia

Booth 41

We extend a cordial invitation to all of you to visit our exhibit where our representatives will be pleased to show and demonstrate the new items we are showing that we feel will be of interest to you. Be sure to see the "New Bio-Dynamics Coagulation Meter," the latest development for doing One Stage Prothrombin Time Tests and Partial Thromboplastin Time Tests in your office. Tests can be done by your regular office assistants.

Representative: Mr. Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Representative: Mr. Harold L. Ashworth.

PARKE, DAVIS & COMPANY
Detroit, Michigan

Booth 22

Parke-Davis is proud of more than a century of service to the medical profession. Our representatives consider it a pleasure to contribute to the success of your meeting. They will be present to discuss the quality products from Parke-Davis, and welcome your comments or inquiry.

Representatives: Mr. R. K. (Bob) Hamilton and Mr. J. A. (Joe) Mayes.

PFIZER LABORATORIES
New York City, New York

Booth 15

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Representatives: Mr. J. Passero and Mr. G. MacPhee.

WM. P. POYTHRESS & CO., INC.
Richmond, Virginia

Booth 3

The Poythress exhibit will feature Trocinate, a unique, direct-acting (musculotropic) antispasmodic drug, and the Mudrane combinations, established Poythress products for relief of bronchial asthma. Solfoton, Solfo-Serpine, Panalgesic and Synirin will also be featured. Your requests for literature and professional trial quantities are cordially invited.

Representative: Mr. Hugh P. Mackey.

PROGRAMMED LEARNING, INC.
Garden City, New York

Booth 30

Engaged in one of the nation's most dynamic industries—Programmed Education. The firm makes available to professional men as well as to students on all levels—the most dramatic technological advance in the remedial and developmental reading field—the automated reading pacer.

Representatives: Saul Levin, Gene Ladoux, Paul Knobler, Sylvia Kasten, Pat Mayer and Dale Schlenk.

A. H. ROBINS COMPANY
Richmond, Virginia

Booth 9

You are cordially invited to visit the A. H. Robins display and meet our representatives who will welcome the opportunity to discuss products of interest with you. Recent new product releases are Dopram® Injectable (doxapram hydrochloride), Repoise® maleate (butaperazine maleate), Sulla® (sulfameter) and Tybatran™ (tybamate).

Representatives: Mr. William W. Leadbetter and Mr. James B. White.

WILLIAM H. RORER, INC.
Fort Washington, Pennsylvania

Booth 14

William H. Rorer, Inc., takes pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss Maalox®, Ascriptin®, Ananase,® Quaalude® and our other products with you.

Representatives: Mr. Omar L. Dowdy, Mr. Charles R. Short, and Mr. Thomas B. Hudson.

ROSS LABORATORIES
Columbus, Ohio

Booth 11

Ross Laboratories presents: Rondec DSC™ oral decongestant, available in three age-graded dosage forms; Rondec T™ oral decongestant tablet; Similac® infant formula products, featuring Similac Isomil for milk-sensitive infants, and Similac Ready-To-Feed; Pediamycin™, erythromycin ethylsuccinate, Ross, oral antibiotic for infants and children; and Vi-Daylin® vitamin products, delicious flavor "just right" vitamin supplements. Be sure to stop by our Booth 11.

Representatives: Mr. Steve McClure, Mr. Jack McCabe and Mr. Joe Salonick.

PHILIPS ROXANE LABORATORIES
Columbus, Ohio

Booth 17

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Mellaril, Sansert, Cafergot P-B and Fiorinal. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Representative: Mr. Ed Curtis.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 44

Saunders will have on display a complete line of its medical books, including many new titles and new editions published since last year's meeting.

Representative: Mr. J. Perry Duncan.

SCHERING CORPORATION
Union, New Jersey

Booth 20

Schering Laboratories invites you to visit its exhibit at Booth 20, where its representatives will be available to discuss with you any question you may have on Etrafon®, Afrin®, Celestone®, Soluspan® Injection, Tinactin®, Drixoral®, Valisone®, Garamycin®, or any other Schering product.

Representatives: Mr. Jack Rogers, Mr. John Carpenter and Mr. Alex Vaughan.

SMITH, MILLER & PATCH, INC.
New York City, New York

Booth 29

Smith, Miller & Patch, Inc., will feature Kondremul, our specialty bowel regulator for the geriatric patient; our hematinic tablets, Vitron-C and Vitron-C Plus; and some ophthalmic products for ocular conditions encountered in general practice.

E. R. SQUIBB & SONS
New York City, New York

Booth 27

Members of the medical profession who search for better agents to prevent and treat disease are eager to learn of new products and improvement in products. Since therapeutic advances are constantly being introduced to the professional market, much valuable product information is available. Your inquiries about the latest results of our research will be welcomed.

Representative: Mr. H. V. Smith.

STATE MEDICAL ASSOCIATION'S GROUP INSURANCE PROGRAM
Charleston, West Virginia

Booth 31

McDonough-Caperton-Shepherd-Goldsmith, administrators of the State Association Group Insurance Program, will have on hand brochures describing each of the programs officially sponsored by the Association. A representative will be available to answer your questions regarding the operation of the plans available. The program has been in successful operation for over 20 years. Don't overlook the opportunity to obtain sound protection at low group rates.

Representatives: Mr. A. B. Daniel and Mr. J. Banks Shepherd.

STUART DIVISION
ATLAS CHEMICAL INDUSTRIES, INC.
Pasadena, California

Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Division booth. Trained representatives will be in attendance to answer your questions on our products. Dialose®, Dialose® Plus, Mulvidren®, Mulvidren®-F, Mylanta®, Mylicon®, Stuart Prenatal®, Stuart Prenatal® w/Folic Acid, and Sorbitrate®.

Representatives: Mr. Arthur Mackail and Mr. Paul Jones.

THE UPJOHN COMPANY
Kalamazoo, Michigan

Booth 23

Professional representatives of The Upjohn company are eager to contribute to the success of your meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

WARREN-TEED PHARMACEUTICALS, INC.
North Chicago, Illinois

Booth 2

WYETH LABORATORIES
Philadelphia, Pennsylvania

Booth 28

Wyeth will feature . . . Ovral® each tablet contains 0.5 mg. norgestrel with 0.05 mg. ethinyl estradiol, Wyeth; Largon® (propiomazine hydrochloride) Wyeth, Injection; Phenergan® (promethazine hydrochloride) Wyeth, Injection. Full information is available at Booth 28.

Representatives: Mr. W. R. Haislip, Jr., and Mr. T. J. Marchal.

ANNUAL REPORTS

Insurance Committee

Our Association sponsors seven separate plans of group insurance for the benefit and use of our members. This broad selection of plans enables a member to "tailor" a program of protection to meet his individual needs—all at low group rates.

During 1969, all seven plans registered increases both in member participation and in the amount of coverage in force.

One of the largest increases was under the Million Dollar Excess Liability Plan. The need for this protection developed when judgments in malpractice and automobile claims assumed an alarming upward trend. These record setting verdicts began on the West Coast several years ago and have spread rapidly across the country. Physicians seem particularly vulnerable to this jumbo type claim. The Excess Liability policy (sometimes called the Umbrella policy) provides $1,000,000 of excess liability protection over regular liability policies. This includes malpractice, auto, home, office, and personal activities.

There has been a substantial expansion in the Group Investment Program. The new service includes a coordinated portfolio of Mutual Funds, Fixed and Variable Annuities, and Split Funds. This broad based investment program enables you to put surplus earnings to work under qualified investment management for your own future use. The object is long term growth, capital appreciation and reasonable return. It offers a very sound arrangement for those who elect to participate. All plans are set up to make full use of the tax shelter now available under HR-10 for those who choose to qualify.

Our Group Insurance Program continues to provide a model of coordinated performance. With record participation, prompt service and efficient administration, our plan has received national recognition for outstanding service to members.

Respectfully submitted,

Charles A. Hoffman, M. D.
Chairman

Robert L. Chamberlain, M. D.
R. U. Drinkard, M. D.
A. C. Esposito, M. D.
F. Perry Greene, Jr., M. D.
Upshur Higginbotham, M. D.
Kenneth G. MacDonald, M. D.
Buford W. McNeer, M. D.
Lawrence H. Mills, M . D.

Medical Education and Hospitals

The past year has seen an expansion of the activities of your Committee on Medical Education and Hospitals. We have been encouraged in our efforts by an appreciable increase in interest in medical education on the part of physicians in West Virginia.

Perhaps the single most important achievement in our sphere of activity in the last 12 months has been the formal organization of the West Virginia State Medical and Hospital Associations' Joint Council on Teaching Hospitals. It will be a primary purpose of this group to maintain and improve internship and residency programs in West Virginia and to fill as many of them as possible with capable young physicians. Later, it is expected that the Council will involve itself with graduate education of paramedical personnel.

Membership on the Council includes three representatives of the West Virginia State Medical Association; three representatives of the West Virginia Hospital Association; one representative of the West Virginia University School of Medicine; and three representatives of each hospital which maintains or is affiliated with one or more approved graduate programs.

Three members of your Committee represent the State Medical Association on the Council. They are: Dr. David Z. Morgan of Morgantown, who has been serving as Chairman Pro Tempore of the Council; Dr. Forest Cornwell of Beckley; and your Chairman. In addition, some other members of your Committee serve on the Council as representatives of their hospitals.

The Council has held two organizational meetings so far, both of which were well attended. At the second meeting, a Constitution and By-Laws were adopted, and permanent officers will be elected at the third meeting, which probably will be held this fall. It is hoped that the Council can devise and implement its program within the next few months.

Your Committee commends the officers and members of the West Virginia Hospital Association for their part in the formation of the Joint Council.

In the field of continuing education, your Committee has several activities to report.

A "Special Open Meeting on Postgraduate Medical Education" was held during the 101st Annual Meeting of the West Virginia State Medical Association last year under the sponsorship of your Committee. We were fortunate to have as our guest speaker at that time Dr. Frank M. Woolsey, Jr., Associate Dean and Professor and Chairman of the Department of Postgraduate Medicine at Albany Medical College.

Since last August, your Committee has co-sponsored four postgraduate medical education seminars. In cooperation with the West Virginia Regional Medical Program, we conducted: "Rehabilitation of Heart, Cancer and Stroke Patients" in Morgantown, September 20-21; "Diagnosis and Management of Vascular Diseases of the Brain" in Martinsburg, September 29; and "Endocrine Disorders" in Morgantown, October 6.

In cooperation with the West Virginia Thoracic Society and the West Virginia University Medical Center, we sponsored a postgraduate course in chest disease on January 26 in Charleston. More one-day seminars are planned for the coming year.

Your Committee was represented at a Conference of State Medical Society Representatives on Continuing Medical Education, which was sponsored by the American Medical Association in Chicago last November; and at the annual AMA Congress on Medical Education.

Exploratory discussions were held during the year concerning the possible establishment of a West Virginia Medical Education Radio Network similar to one now in operation in Ohio. Twice representatives of your Committee met in Morgantown with officials of the Ohio State University College of Medicine, sponsor of the Ohio project. It is felt that an arrangement might be worked out whereby the Ohio and West Virginia networks could be tied together, with members of the faculty of the West Virginia University School of Medicine preparing and presenting a large share of the programs.

Your Committee assumed another major responsibility during the year, that of liaison with the Joint Commission on Accreditation of Hospitals. JCAH asked each state medical society to appoint a committee to review proposed new standards for accreditation, and the officers of the West Virginia State Medical Association concluded that your Committee provided the best framework for this purpose. A subcommittee headed by Dr. Daniel Hamaty was organized for this purpose.

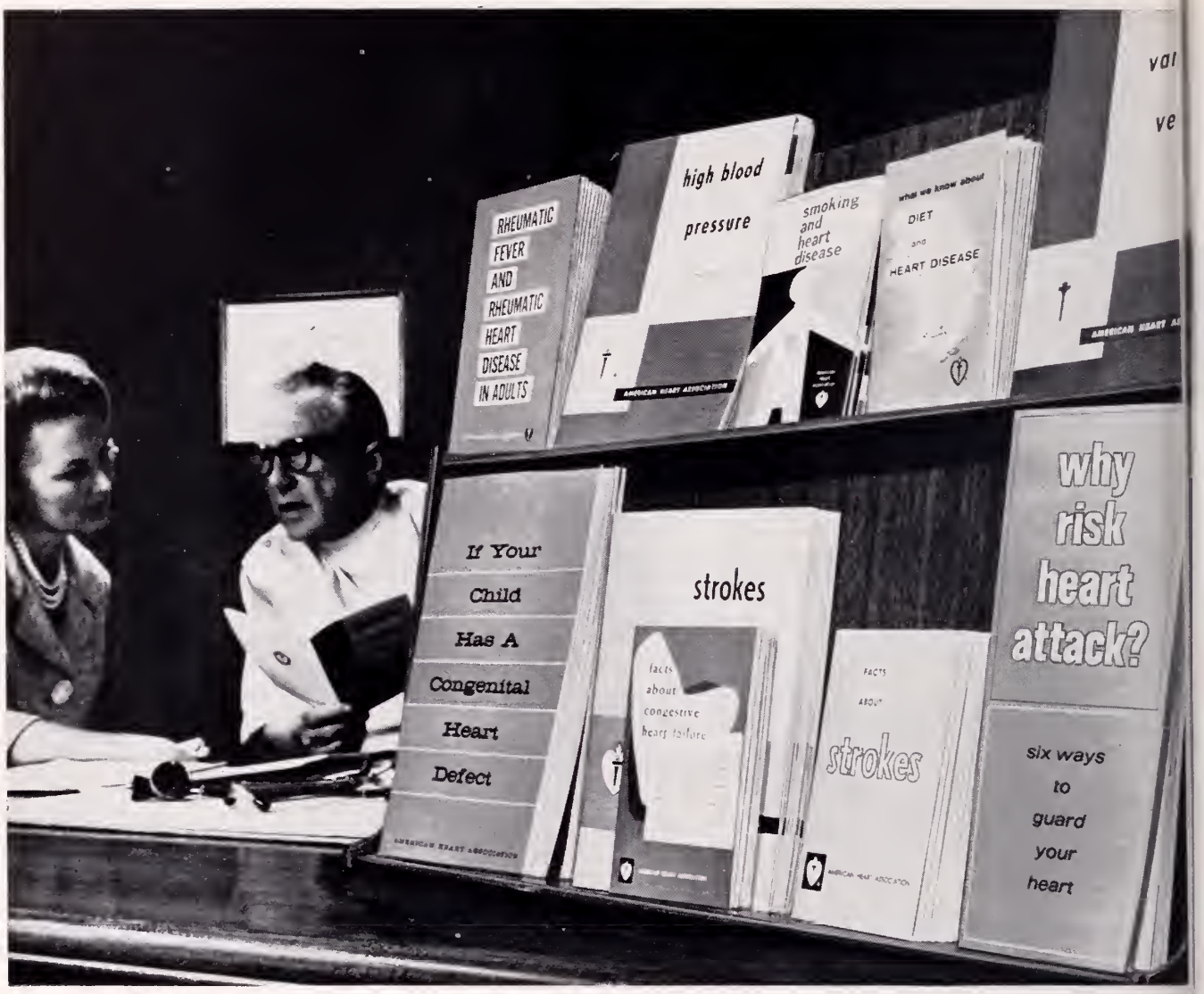
The Subcommitte has held two meetings and was represented at two JCAH meetings in Chicago earlier this year.

Doctor Hamaty's Subcommittee seeks to keep abreast of the operations of JCAH and its rules, regulations and standards; to serve as a body for consultation by the membership of the State Medical Association; to receive comments from members of the State Medical Association regarding the activities of JCAH at their hospitals, including the receipt of grievances resulting from field surveys.

Respectfully submitted,

Pat A. Tuckwiller, M. D.
Chairman.

Charleston,
June 13, 1969



Your Heart Association can help you help your patients

Your patients and their families might have questions about the heart and blood vessel diseases. Your Heart Association has prepared a variety of pamphlets to assist you in answering their questions in simple non-technical language.

Produced under the guidance of leading cardiovascular specialists, these pamphlets deal with such subjects as heart attack, stroke, hypertension, rheumatic fever, congestive failure, inborn hea defects, varicose veins and other disorders. Ther are also pamphlets advising on risk factors relate to heart attack, including persuasive argument against cigarette smoking, and a fat-controllec low-cholesterol diet plan for the general public

Booklets on therapeutic sodium-restricted o cholesterol-lowering diets are also available on a physician's prescription only.

Ask your local Heart Association for a catalogue listing all these free materials and order a supply

WEST VIRGINIA HEART ASSOCIATION
211 Thirty-Fifth Street, S. E.
CHARLESTON, W. VA. 25304

Courtesy of the Publisher.

The West Virginia Medical Journal

Vol. 65, No. 9 September, 1969

Renovascular Hypertension

Thomas J. Tarney, M. D., and Herbert E. Warden, M. D.

Hypertension is lethal. After discovery, affected individuals live only about 16 years. Approximately three per cent of the population of the United States have abnormally high blood pressure. Curable ischemic renal disease is responsible for five per cent of this total. Thus, about 3,000 individuals with potentially rectifiable renovascular hypertension exist in West Virginia. In the greater Charleston-Huntington area, the number should be in excess of 300.

Historical Development

Although Richard Bright, in 1827, indicated a relationship between cardiac and renal disease, it was not until 1898 that Tigerstedt and Bergman showed extracts of renal cortex contained pressor activity (Table 1). Years later, Goldblatt produced permanent hypertension by renal artery constriction. In rats and man, a unilateral lesion sufficed while in dogs, contralateral nephrectomy or bilateral narrowing was required. Subsequently, perirenal fibrosis and renal vein compression were found to create elevation of blood pressure.

Initially, renin itself was thought to be the pressor, but eventually renin was shown to be an enzyme which converted a plasma factor, renin substrate (angiotensinogen), to the active principle, angiotensin.

Renin-Angiotensin Mechanism

Renin is elaborated by the juxtaglomerular apparatus in response to changes in pressure and sodium concentration as shown diagramatically in Figure 1. Pressure variations in the afferent renal artery probably are sensed directly while the response to sodium ion changes may be mediated through the macula densa located immediately adjacent. The granularity of the juxtaglomerular cells, the juxtaglomerular index (JGI), has been used as a measure of renin elaboration. Hypotension causes the number of granules and the total extractable renin from the kidney to increase. An elevated pressure produces a decrease in the number of granules. In unilateral renal coarctation, hypergranulation is regularly observed in the affected kidney while very few granules can be identified in the contralateral organ which has been subjected to increased pressure.

Renin is an enzyme of unknown structure that cleaves a chain of 10 amino acids from a glycoprotein with a molecular weight of approximately 57,000. This protein travels with the alpha$_2$ globulin fraction of plasma. The formed decapeptide is moderately hypertensive but is quickly converted to the octapeptide by converting enzyme present in plasma and in the lungs.

The chemical structure of angiotensin in various species is similar except in the 5 position. The equine and human forms contain isoleucine at this location while valine is found in the bovine and commercial preparations.[1]

Angiotension is a powerful, smooth muscle constrictor. It has a short half-life and may be completely cleared from the circulation in a single passage. Renin, with a half-life of about 20 minutes, persists somewhat longer.

Angiotensin exhibits 10 to 25 times more pressor activity per milligram than norepinephrine. In equipressor doses, angiotensin elicits only

The Authors

- **Thomas J. Tarnay, M. D., and Herbert E. Warden, M. D., Department of Surgery, West Virginia University Medical Center, Morgantown.**

Submitted to the Publication Committee February 7, 1969.

one-fifth the vasoconstrictive effect on veins and for this reason has been suggested for use in cardiogenic shock;[1, 2] peripheral pressure is increased without a corresponding rise in central venous pressure.

The mechanism of angiotensin action is unknown and is not related to the catecholamine system. Neither alpha nor beta blocking agents decrease activity, but angiotensin does potentiate the effect of these vasoactive amines. Denervation decreases the pressor responses to angiotensin.[1, 3]

Renal blood flow is reduced by angiotensin because of arterial constriction. Glomerular filtration is similarly lowered. More complete absorption of sodium, potassium, and chloride is expected since the ultrafiltrate is present in the tubules for a longer period and lesser amounts of these ions should appear in the urine.[1]

Angiotensin appears to be the prime regulatory substance for the elaboration of aldosterone. The greater the circulating angiotensin, the greater the rate of aldosterone output.[4] Indeed, secondary hyperaldosteronism, manifest by low serum potassium and elevated bicarbonate, may be observed in patients with renal artery stenosis.[5] The direct pressor effect of angiotensin and the sodium retaining ability of aldosterone work synergistically to maintain the circulation in shock.

Angiotensin and renin levels are elevated in the blood of patients with renovascular hypertension. In hyperaldosteronism (Conn's disease), the rate of renin secretion approaches zero. The values are normal or decreased in essential hypertension but are greatly increased in the malignant phase of hypertension.[6] Some edematous states in normotensives, such as congestive heart failure and cirrhosis with ascites, are associated with elevated quantities of renin and angiotensin in the circulation.[7] Why the blood pressure is not elevated is unknown.

Etiology

Table 2 lists the clinical causes of renovascular hypertension. The most frequent lesion is arteriosclerosis. The obstruction is commonly near the origin of the renal artery and ordinarily does not extend far into the vessel. Often, though not invaribly, there is poststenotic dilatation (Figure 2). Thirty to 40 per cent are bilateral.

Fibromuscular hyperplasia usually occurs in women in the second and third decades. It is more frequent on the right. The origin of the renal artery from the aorta tends to be normal but within a centimeter the lumen becomes irregular and corrugated. The lesion may extend to the point of vessel division. Whether the abnormality is congenital or acquired is not known.

Only about 20 per cent of renal artery aneurysms cause hypertension. These frequently occur near the site of arborization and cause compression of one or more of the branches. Since the blood supply to the kidney is on a segmental basis and the collateral circulation between segments is poor, sufficient local ischemia occurs for excessive elaboration of renin.

Strictures are frequently congenital and may occur anywhere within the renal arterial system. Any cause of vessel compression, whether it be a hydatid cyst, a hematoma, or an abnormal adhesion band, can similarly result in hypertension.

Table 1.

Historical Developments in Renovascular Hypertension

Discovery of Renin	1898	Tigerstedt & Bergman
Temporary Hypertension Produced by Renal Artery Branch Constriction	1909	Janeway
Relief of Hypertension by Nephrectomy	1927	Crabtree
Renal Artery Constriction Observed at Post-Mortem in a Hypertensive	1929	Ask-Upmark
Renal Artery Constriction Discovered to Produce Permanent Hypertension	1934	Goldblatt
Discovery of Angiotensin	1939	Page, Braun-Menendez, Fasciolo, Leloir, & Munoz
Cellophane Wrapping of the Kidney Created Hypertension	1940	Page
Antirenin Found to Alleviate Hypertension	1940	Wakerlin
Juxtaglomerular Cells and Hypertension Thought to be Related	1944	Goormaghtigh
Renal Vein Constriction Found to Elevate Blood Pressure	1950	Blake, Wegria, Ward, & Frank
Synthesis of Angiotensin	1957	Bumpus, Schwarz, Page, Schwyzer, et al.
Fluorescent Antirenin Indicated Juxtaglomerular Cells to be Source of Renin	1960	Hartroft & Edelman

Parenchymatous renal disease with sclerosis of the microvasculature may bring about elevation of the blood pressure. Increased interstitial pressure as in a transplant rejection episode can act similarly. The elevated renin values return to normal after control has been achieved by augmentation of the immunosuppressive regimen. Diffuse vascular disease is a common factor perpetuating hypertension, particularly as the consequence of pressure injury to the "normal" kidney where unilateral coarctation has been present for many years.

Diagnosis

Table 3 lists criteria that may help to uncover a high yield of patients with renovascular hypertension but because of the deadly nature of the disease, every patient with high blood pressure should have this diagnosis considered carefully at least once as a part of his total evaluation. Approximately 65 per cent of abdominal bruits in hypertensives are the result of renal arterial stenosis. Whenever the blood flow to the kidney is diminished, the organ itself decreases in size. If the difference in length of the two kidneys is greater than 1 to 1½ cm. on an abdominal film, renovascular involvement is likely.

Renal artery stenosis may not be apparent on an ordinary intravenous pyelogram. When radiographic exposures are taken at one-minute intervals (timed I.V.P.) during the first five minutes after contrast medium injection, differences in the appearance time of dye between the two kidneys may become apparent (Figure 4-a). The tardy filling in the presence of renal coarctation is followed by delayed emptying of the

Table 2.

Etiology of Renovascular Hypertension

- Coarctation Renal Artery
  - Atherosclerosis
  - Fibromuscular hyperplasia
  - Aneurysm
  - Stricture
  - External Compression
- Coarctation Abdominal Aorta (or hypoplasia)
- Parenchymatous renal Disease
  - Chronic glomerulonephritis
  - Pyelonephritis
  - Transplant rejection crisis
  - Diffuse vascular disease
  - Perinephritis
  - Space-occupying lesions
  - Trauma

Table 3.

Indications for Diagnostic Studies

Hypertensives under age 40
Sudden onset hypertension or rapid acceleration of hypertension
Presence abdominal bruit
Difference in kidney size (1-1.5 cm.)
Abnormal timed IVP

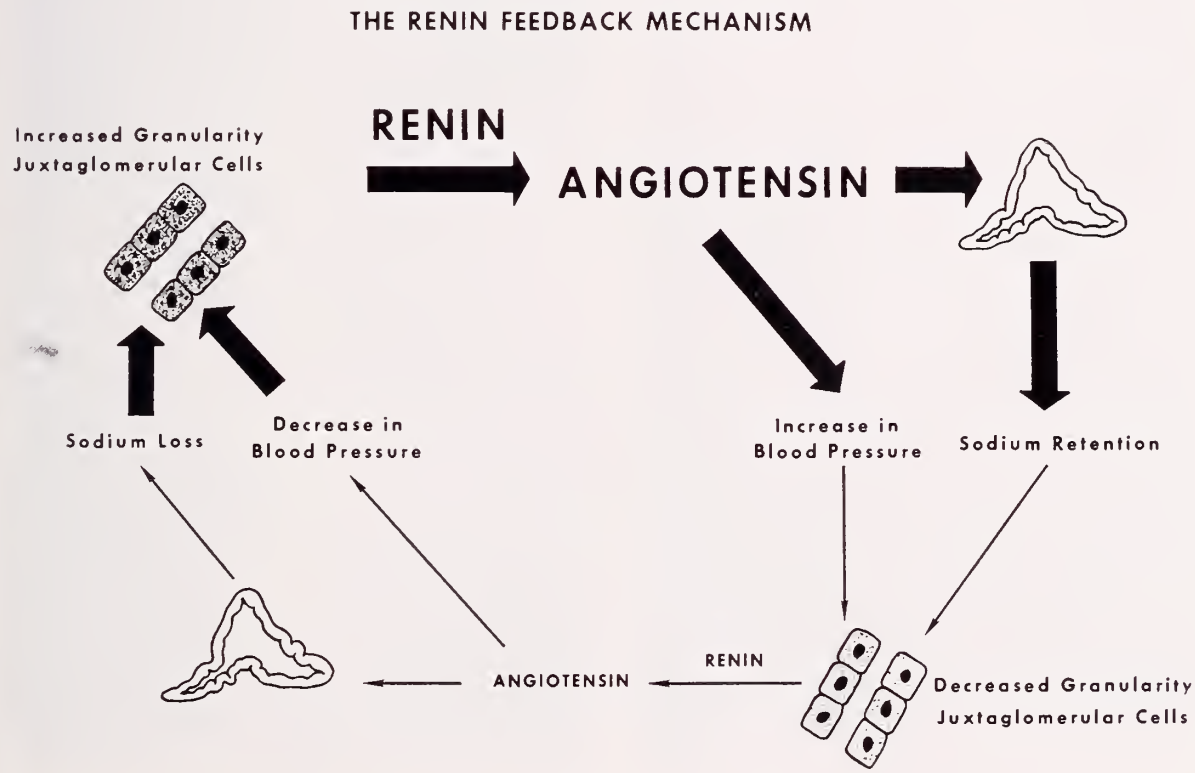


Figure 1

calyceal system because of the reduced rate of urine formation. A late exposure such as the one shown in Figure 4-b can highlight the abnormality. Simultaneous appearance of radiopaque dye in the early postoperative period after a revascularization procedure is a convenient way to certify a successful result.

In the presence of excess circulating angiotensin, the organism develops some resistance. This phenomenon has been exploited as a diagnostic maneuver. Normal individuals respond to a 5-minute, 4 mmcg/kg/min. infusion of angiotensin by an increase in blood pressure of at least 20 mm. Hg.[8] The patient with renovascular hypertension does not, and may not, even if the dose is doubled. A similar effect is seen in certain edematous states also and in pregnancy.[9]

A number of diagnostic procedures have evolved based on the decreased renal blood flow to the involved kidney. The Howard test is the most widely known. Urine flows from each ureter are compared. A volume difference of 100 per cent or more and at least a 15 per cent decrease in sodium concentration on the affected side signifies a decisive test.[1] In practice, the sodium variation has been unreliable. Some consider even a lesser excretory inequality to be significant. In the presence of segmental or bilateral renal arterial occlusion, large urine volume differences would not be expected. A positive result is considered reliable; a negative one is equivocal.

Isotopically labelled indicators, such as I^{131} hippuran, or a mercurial diuretic incorporating Hg^{203} or Hg^{197}, can be employed in two ways: by scintiscan or renogram. The former indicates topographical absorption of radioactive material (Figure 5-a), while in the latter, tracer activity as a function of time is recorded continuously over each of the two kidney areas. Such inscribed curves exhibit three phases (Figure 5-b). The fast rise time denotes arrival of the radioactive isotope from the circulation. The second slower build-up phase indicates excretion of the substance by the kidney tubules. The decay slope reflects the passage of urine into the bladder. A normal kidney exhibits a fast rise time and an elevation to a sharp peak followed by speedy loss of radioactivity due to rapid washout. In total obstruction by ureteral calculus, there is a rapid initial increase, a slower secondary rise, and continued elevation of the curve with no diminution of radioactivity with time. In renal coarctation, the first elevation is of lower amplitude. The secondary increase to a lesser peak is more gradual and is the consequence of the reduced amount of material available for excretion. The decay is much slower than in the contralateral organ since the urine flow is less and the radioactive substance lingers. Bilateral involvement may be inferred

Figure 2: Arteriogram delineates left renal coarctation with poststenotic dilatation.

Figure 3: Abdominal coarctation may cause hypertension if it originates above the renal vessels.

but the observations are not as conclusive as with unilateral coarctation.

Surgical Treatment

Excision may be the only modality of treatment available for the shrunken, nonfunctional kidney. If the hypertension has not been of long duration, improvement may be expected immediately. On the other hand, if the opposite kidney has had the opportunity to develop arterionephrosclerosis, elevation of blood pressure may persist.

Revascularization may be undertaken whenever feasible by a number of methods, depending on the local situation and the surgeon's preference. These include endarterectomy with or without patch graft, reimplantation of the surgically shortened renal artery into the aorta, end-to-end splenic artery to left renal artery anastomosis, and aortorenal by-pass grafts of autogenous veins or Dacron prostheses.

In the event an accessory renal artery is narrowed and does not lend itself to repair because of its small caliber, segmental kidney resection may preserve maximal function. A similar approach may be utilized for uncorrectible lesions of a renal artery branch.

If all else fails, renal transplantation is the only recourse.

Role of Medical Management

Antihypertensive agents are ordinarily effective in hypertension of renovascular origin. The exact role of medication in the treatment of this disease is still uncertain. If a surgically unremediable situation exists and antihypertensive drugs have been shown to control the blood pressure adequately, the indication is clear. On the other hand, in the presence of discrete localized unilateral or bilateral lesions, operation is the procedure of choice even if the patient is easily controlled by drugs. Once surgical relief has been obtained, the physician no longer need concern himself about follow-up. Many patients tend to ingest drugs faithfully initially but, later, because of cost, forgetfulness, or for other reasons, cease medication.

Surgical Results

Results of revascularization or excision procedures vary. Forty to 60 per cent of patients become completely normotensive. Twenty to 40 per cent are improved and 20 per cent remain unchanged.[1, 10] These results are not a function of the surgical procedure but rather the state of the disease. If the "normal" kidney has had time to develop arterionephrosclerosis, the hypertension will persist after correction of a unilaterial lesion. Sometimes excision of "normal" kidney at a subsequent stage can afford permanent relief.[11] Bilateral renal coarctations should be uniformly amenable to cure since protection

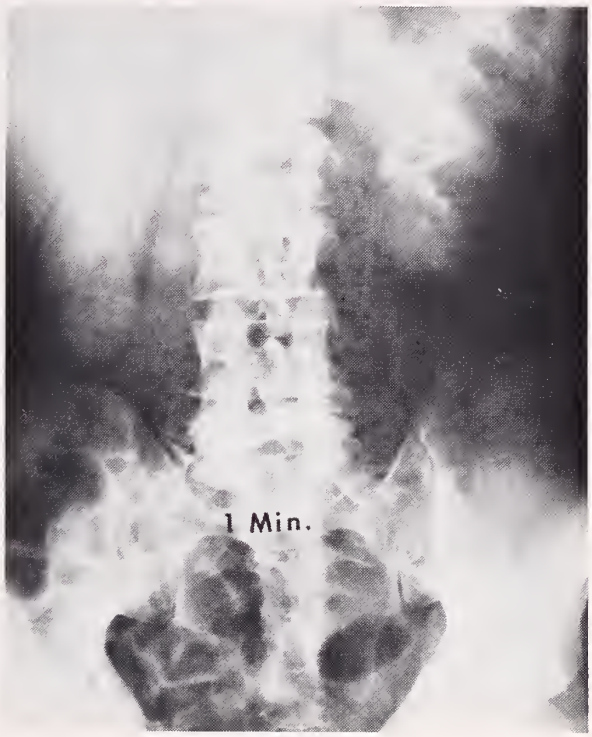


Figure 4-A

Figure 4-B

Figure 4: Intravenous pyelography demonstrates earlier filling of normal left kidney (a) and delayed emptying of right kidney (b) with renal artery stenosis.

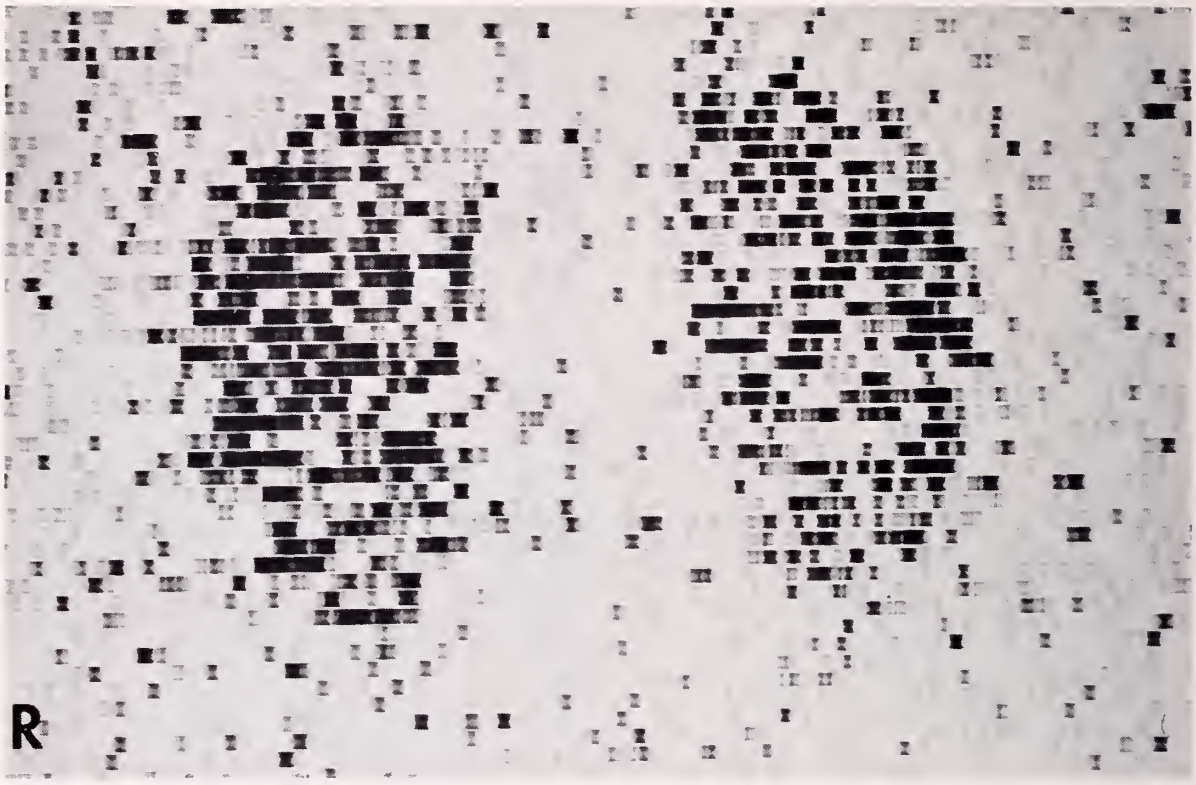


Figure 5-a: Scintiscan of patient with bilateral renal coarctation. A normal kidney should be represented as almost solid black.

is afforded to both kidneys unless the lesions had developed at different times. Whenever one attempts revascularization, biopsy specimens of both kidneys should be taken during the initial procedure in order to anticipate future difficulty and to confirm the histologic normality of the restored organ.

Conclusions

Hypertension is an affliction with a significant mortality. For the majority, the etiology is unknown. The few with renovascular disease and other surgically rectifiable forms should not be overlooked because a cure may be possible. Thus, every hypertensive should have a complete evaluation, including consideration of a renovascular mechanism, at least once during the course of his disease. In West Virginia, case finding is particularly important since the number of potential candidates for relief far exceed that of those already corrected.

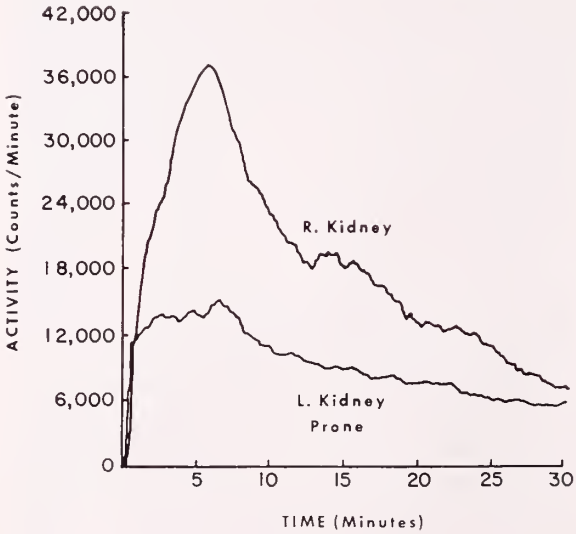


Figure 5-b: Renogram shows clear distinction between the normal right kidney and the ischemic organ on the left.

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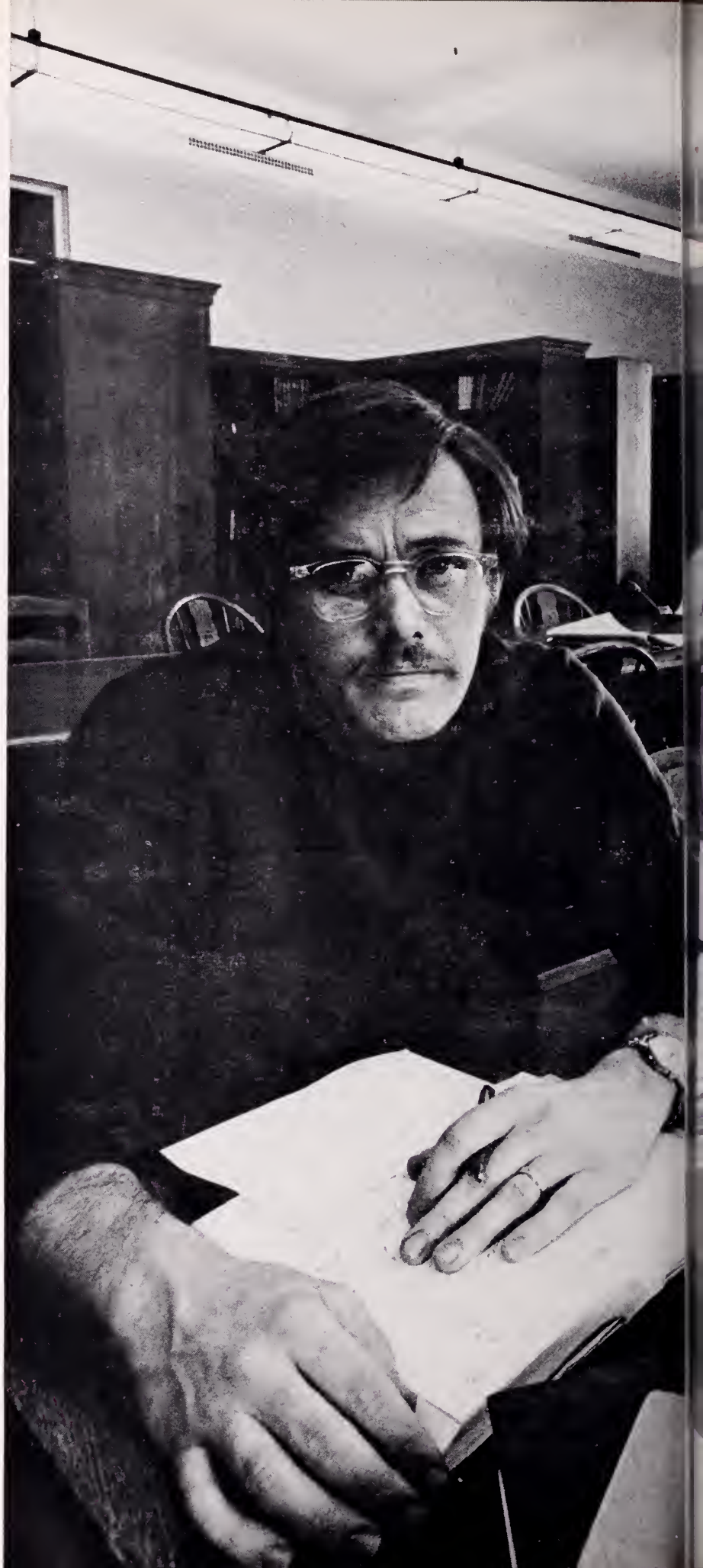

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Carcinoma of the Breast

T. H. Chang, M. D.

The purpose of this paper is to review the 194 cases of carcinoma of the breast treated at Broaddus Hospital, Philippi, West Virginia, between 1945 and 1963.

Sixty-eight cases had metastasis to the axillary lymph nodes. These were treated by radical mastectomy and were compared with 77 cases that did not have metastasis to the axillary lymph nodes. The results of the treatments were analyzed to compare the survival rates.

In carcinoma of the breast, correlation between duration, size of tumor, lymphatic spread and degree of cellular differentiation and invasiveness is not as well established as in other sites and uncommonly serves as a basis for therapy. Patients with large undifferentiated tumors of long duration may live many years after radical mastectomy while others with small, localized, presumably early and well differentiated tumors may die from distant metastasis within a few months. MacDonald[4] has called this trait "biologic predeterminism". According to his view, some patients with breast cancer are incurable by any form of treatment. Some are curable by less than radical operation and some are curable only by radical mastectomy. According to MacDonald,[4] the survival rate of any series should not be greater than 45 per cent if all cases, operable and inoperable, are counted.

Halsted, in 1890, introduced radical mastectomy. Since then, this procedure has been virtually unchanged. Radical mastectomy requires a precise knowledge of anatomy and meticulous adherence to operative detail.

In recent years, however, progress has been made in defining the criteria of operability. Ancillary therapy such as preoperative and postoperative irradiation has been used extensively and McWhorter[1] has advocated simple mastectomy with massive irradiation. The extended radical operations of Dahl-Iversen,[3] Urban[2] and others also have been used to a limited extent. Great care must be exercised in determining operability by radical mastectomy. Clinical staging of mammary carcinoma by anatomic and biologic criteria is useful.[3]

Submitted to the Publication Committee, April 21, 1969.

The Author

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Stage I — Radical mastectomy
- A — Radical mastectomy

Stage II
- B — Radical mastectomy or Selective irradiation

Stage III — Selective—Irradiation
- —Hormonal (ablative or additive)
- —Palliative surgery to avoid ulceration
- —Chemotherapy

Between 1945 and 1963 a total of 194 cases of carcinoma of the breast were treated in this hospital. Following are the number in each age group:

1 – 18 years	1
19 – 39 "	4
40 – 64 "	136
65 – 79 "	48
80 – 99 "	5

There were 53 per cent Stage I, 32 per cent Stage II, and 15 per cent Stage III.

Radical mastectomy was performed in 148 cases, or 76 per cent, simple mastectomy in 25 cases, 12.3 per cent, and deep x-ray therapy, chemotherapy or hormone treatments in 23 cases.

Group I.—In this group 77 patients underwent radical mastectomy. This group did not have metastasis to the axillary lymph nodes. In this group there were 64 Stage I, 13 Stage II, and no Stage III. Postoperative irradiation was not administered until and unless it was proved that the patient had recurrent or metastatic carcinoma.

Group II.—In this group, 35 were Stage I, 29 were Stage II, and 4 were Stage III. These patients underwent radical mastectomy and axillary metastasis was proved by pathologic examination.

After radical mastectomy, postoperative irradiation was not administered except in the cases of four Stage III patients.

In recent years, radical mastectomy was limited to Stage I and Stage II. During the studies, four Stage III patients underwent the procedure.

Group III.—In this group of 24 cases, five were Stage I, 12 Stage II, seven Stage III. All underwent simple mastectomy. Stage I patients either were very old patients or patients referred for Cobalt-60 teletherapy following operation elsewhere.

Group IV.—Disseminated nonoperable cases mainly were treated with irradiation, chemotherapy and hormonal alteration.

Results

Group I.—The five-year survival rate in the cases of 77 patients who underwent radical mastectomy with a diagnosis of breast carcinoma without metastasis was 75 percent (58 patients).

Group II.—In cases of radical mastectomy with a diagnosis of breast carcinoma with metastasis, of 68 cases the five-year survival rate was 48.5 per cent (33 patients).

Group III.—The five-year survivals undergoing simple mastectomy were six patients or 25 per cent. With the exception of eight patients, these were referred for Cobalt therapy and had undergone operation elsewhere. This group was mainly Stage II and Stage III. This probably accounts for the fact that the survival rate is very low. An interesting fact is that until 1952, these

Table I

CLINICAL STAGING

		Stage I (53%)	Stage II (32%) A	Stage II (32%) B	Stage III (15%)
Radical Mastectomy (76%)	Group I ca of breast $\bar{s}$ metastasis to axillary lymph nodes	64	7	6	0
	Group II ca of breast $\bar{c}$ metastasis to axillary lymph nodes	35	20	9	4
Group III Simple Mastectomy 24		5	1	11	7
Group IV Disseminated Cases 23		0	0	5	18

Table II

SURVIVAL RATE – 55%

Total		5 years
194		
Radical Mastectomy 148	Group I (77) ca breast $\bar{s}$ metastasis to axillary lymph nodes	58 (75%)
	Group II (68) ca breast $\bar{c}$ metastasis to axillary lymph nodes	33 (48.5%)
Group III Simple Mastectomy 24		6 (25%)
Group IV Inoperable, Disseminated Cases (Irradiation (Hormonal alteration (Chemotherapy		0

patients received x-ray therapy and the survival was only one out of nine. Fifteen patients received Cobalt-60 teletherapy and the number of five-year survivals was four. Simple mastectomy plus irradiation and chemotherapy was the treatment used. Nonoperable cases with a five-year survival rate was zero.

In comparing the five-year survival rate between Group I and Group II, it was found to be 75 per cent and 48.5 per cent, respectively. The difference might have been affected by the fact that Group II had four Stage III cases and 29 Stage II cases while Group I had no Stage III cases and only 13 Stage II cases.

It is, however, stated that lymphatic drainage from the outer half of the breast and areola is predominantly to the axillary nodes. The inner half drains to either or both the axillary and internal mammary chain. When axillary nodes are involved, internal mammary nodes are involved in about 50 per cent; therefore, patients who undergo radical mastectomy and prove to have metastasis to the axillary lymph nodes should have routine postoperative irradiation. In doing so, Group II may approach a survival rate of 75 per cent.

Case Reports

(*Case 1-A.*)—This 51-year-old white female had a history of a firm, nodular mass in the outer quadrant of the left breast of four months' duration. On physical examination, a firm, nodular mass measuring 3 x 2 cm. was found in the left breast but axillary nodes were not palpable. The patient underwent left radical mastectomy and the anatomical diagnosis revealed grossly a large mass measuring 8.5 cm. in greatest dimension. Multiple sections revealed the breast tumor to be an infiltrating anaplastic epithelial tumor with a tendency to the formation of cells with atypical appearance (Figure 1). Axillary lymph node metastasis (Figure 2). Metastasis to the left femur subsequently developed and she received Cobalt-60 teletherapy, 2700 "r" to each of three fields in the axillary and supraclavicular areas. She was also treated with Thiotepa. She expired within six months.

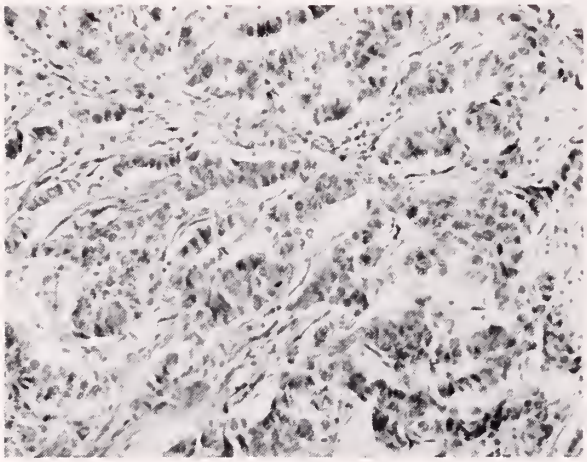

Figure 1

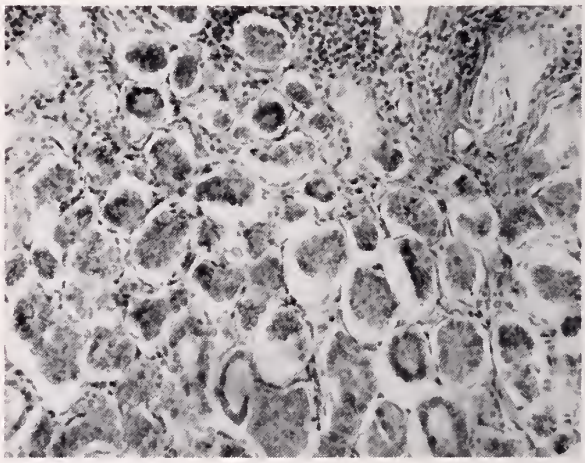

Figure 3

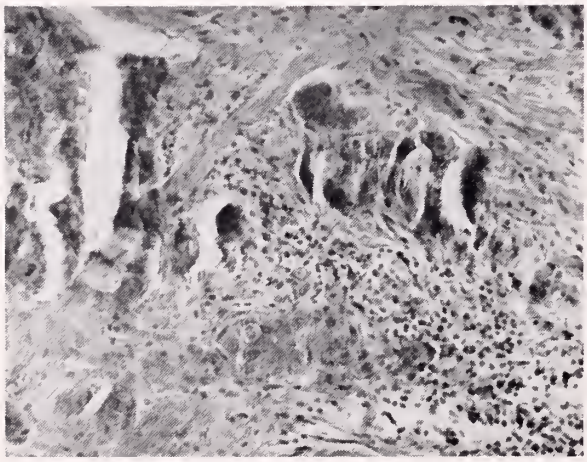

Figure 2

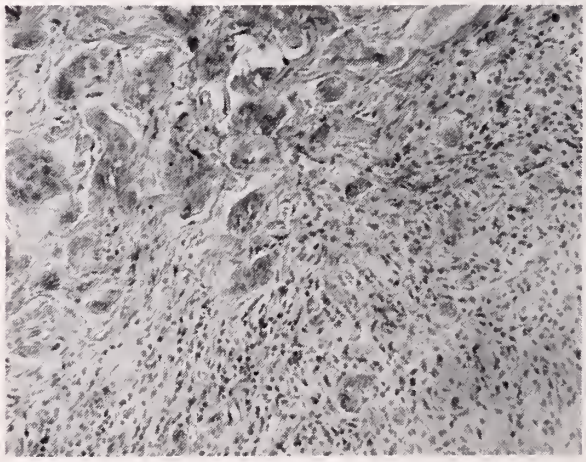

Figure 4

(*Case 2.*)—This 58-year-old white female was admitted with a history of a lump in the right breast for one year. The patient stated that the mass had grown very little since she first noticed it. On examination, a firm mass measuring approximately 5 x 4 x 3 cm. was found in the upper inner quadrant of the right breast. This was clinically Stage I. The patient underwent radical mastectomy and the anatomical diagnosis was carcinoma of the breast with extensive metastasis in 10 of 11 axillary nodes. The patient lived four years after operation (Figures 3 & 4).

Summary

1. The survival rate of carcinoma of the breast is reviewed and various treatments for carcinoma are discussed.

2. Conventional radical mastectomy continues to be the choice of treatment for Stage I and Stage II breast cancer. Great care must be exercised, however, in determining operability by radical mastectomy.

3. One hundred forty-eight patients underwent radical mastectomy between 1945 and 1963 inclusive, and the survival rates were compared between the Group I and Group II series. It is felt that the treatment of choice in carcinoma of the breast with axillary metastasis is radical mastectomy followed by routine postoperative irradiation. Two typical cases of Group II breast cancer with metastasis to the axillary lymph nodes are reported. One of these was clinically Stage I carcinoma of the breast, with 10 out of 11 lymph nodes involved.

Of 194 cases of carcinoma of the female breast of all four groups, 97, or 55 per cent, survived five years. The longest survival period in this series is 21 years. A follow-up study in another five years, 10 years, and 15 years will be necessary to determine the long-term survival rate.

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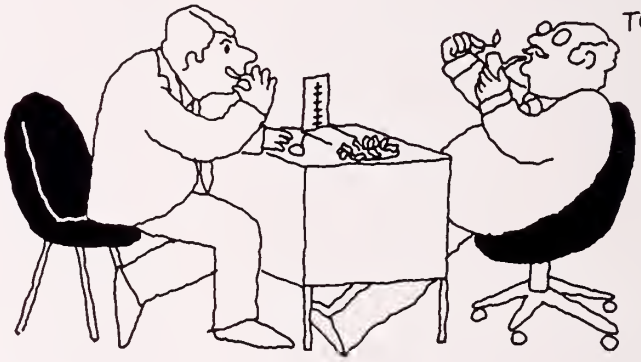

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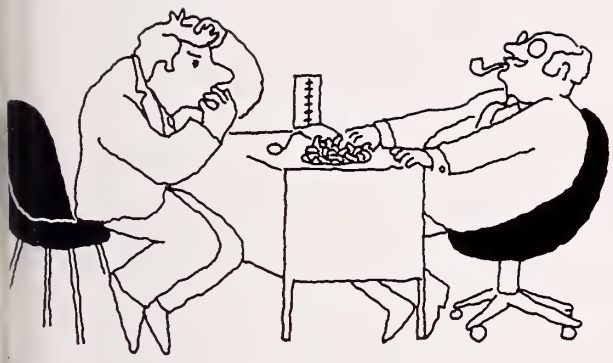

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Smallpox Vaccine Encephalomyelitis

(Case Report)

Louis A. Vega, M. D.

VACCINATION against smallpox has been practiced in the United States since the beginning of the 19th Century, and for many years it has been a known fact that it carries a risk of central nervous system complications. The latter rarely follow vaccination in infants under the age of two years, most cases occurring in children undergoing primary vaccination at a later age.

Incidence.—There is great variation in the incidence of postvaccinal encephalitis throughout the world. In certain places at certain times, more than one case has occurred in every thousand vaccinations and, again, several million vaccinations have been performed without the discovery of a single case.

In 1963, there were 14,014,000 vaccinations against smallpox in the United States (6,239,000 primary and 7,775,000 re-vaccinations). Of this number, there were 12 cases of postvaccinal encephalitis reported, with five deaths.[1] Seven cases occurred in children between the ages of five and nine years, with three deaths in this age group. As of September 23,[2] there have been eight cases of postvaccinal encephalitis (all in primary vaccinations) reported in the year of 1968, with two deaths occurring in this group (There may be another probable encephalitis death reported in the month of October, 1968).

Mechanism.—The mechanism of vaccinia encephalitis remains obscure: possible direct invasion of the central nervous system by the virus, activation of some latent neurotropic virus strain, and an antigen-antibody reaction, essentially allergic in character, have been suggested.

Clinical Picture.—According to Ford,[3] following an incubation period that varies from 2-25 days, the child becomes ill rather abruptly, with fever, headache and vomiting. This onset is followed by convulsion, stupor and coma within a few hours. Encephalic and spinal cord symptoms and signs are almost always present. At the time of the central nervous system involvement, the local reaction usually is not remarkable.

Presented to the Publication Committee March 3, 1969.

The Author

- **Louis A. Vega, M. D., Department of Pediatrics, Stevens Clinic Hospital, Welch, W. Va.**

Laboratory.—The spinal fluid is clear and usually contains few cells, predominantly lymphocytes. Of the 12 cases that occurred in 1963, (all had spinal taps performed) only seven children had cells in their spinal fluid; in five, the cell count was less than 50 per cubic mm.; the other two had spinal fluid cell counts of 100 and 532 per cubic mm., respectively. Spinal fluid protein usually is slightly elevated. Sugar is normal and bacterial cultures are negative. The smallpox vaccine virus has been recovered from the spinal fluid in a few cases.

Mortality.—Mortality usually is high and averages 30-40 per cent. If the child survives, recovery is almost always complete, with severe sequelae being exceptional. Going back to the 12 cases reported in the 1963 survey of the seven survivors, one seven-month-old infant was left with severe brain damage.

Treatment.—Although ACTH was used in the treatment of vaccinia encephalitis as early as 1951[4], steroid therapy has not been recommended in the past, in view of the profound effect of steroids in facilitating viral invasion in experimental animals.[5]

Vaccinia immune globulin (VIG) has no apparent beneficial effect in the treatment of vaccinia encephalitis.[6] Primary vaccination should be carried out in children between the ages of 16 and 24 months.

Case Report

(No. C-14,604). A six-year-old Caucasian female was admitted to Stevens Clinic Hospital, Welch, West Virginia, on the evening of September 16, 1968, with the chief complaint of severe convulsions, which apparently started two hours prior to admission.

On September 15, 1968, fever and frontal headache had developed for which she had been

given five grains of aspirin by her mother. The following morning she felt well enough to go to school. She came home that evening again complaining of frontal headache and nausea and later vomited a couple of times.

She was taken to her family physician where, approximately 20 minutes later, she started to twitch in both upper extremities and became unresponsive, lapsing into a deep coma. On August 27, 1968, she had received her primary smallpox vaccination by her family physician, from which a typical "take" had developed. Other routine immunizations, including measles vaccine, had caused no systemic symptoms.

Natal History.—This child, weighing 7½ pounds at birth, was born at another hospital. Her delivery was apparently normal. Neonatal and post-natal motor and mental development were apparently within normal limits.

Family History.—The family history was negative for tuberculosis, syphilis and diabetes. Two aunts had epilepsy. Both parents were living and well. Four siblings were living and well. One 15-year-old sister was known to have possible epilepsy. One sibling had died at the age of three days, apparently from prematurity.

Past History.—Mild illnesses such as upper respiratory infections and tonsillitis with slight fever, but no previous history of convulsions.

Physical Examination.—Examination revealed a very pale, acutely ill, female child, with severe twitching of the mouth, mandible, and upper and lower extremities. Blood pressure 120/40. Pulse 140 per minute. Temperature 100 F., rectally. Respiration 28 per minute. Pharynx with bloody mucous. Throat and tonsils were negative. Neck, supple. The lungs were clear to percussion and auscultation. Heart: Normal sinus rhythm. No murmur. Abdomen negative. Liver not palpable. Extremities negative. Good femoral pulsation. Skin: Smallpox vaccination scab of left deltoid region, measuring about 1½ cm. in diameter. No local reaction.

Neurological Examination.—Lateral nystagmus. Pupils were round and equal, reacted well to light. Corneal reflexes were sluggish. Fundi were apparently normal. There was some decrease in muscle tone. Reflexes were hypoactive and deep tendon reflexes were absent. Babinski and Kernig's signs were absent. There was no withdrawal response to painful stimuli.

Treatment.—A proper airway was secured and oxygen was administered by nasal catheter. Suction was used as needed. Amobarbital Sodium (grains 1⅞ diluted in 5 cc. of sterile water) was given slowly intravenously. This controlled the seizures temporarily. A spinal tap was done. The cerebrospinal fluid was clear. Opening pressure was 440 mm. of water. Cell count, 40; neutropils, 11; lymphocytes, 26; RBC, 3; protein, 10; Pandy, negative; sugar, quantity not sufficient. Transaminase level was less than 50 units.

Seizures recurred approximately one hour later, requiring additional intravenous Amobarbital Sodium. Five per cent dextrose in saline with calcium gluconate, 10 cc. and 500 cc. of fluid were started intravenously to prevent respiratory depression following the intravenous barbiturate. Intravenous Dexamethasone was started approximately at 8:00 p.m. Four mg. were given at four-hour intervals. Vital signs were monitored at one-hour intervals for the first few hours after admission. The child's seizures gradually decreased. About 2:00 a.m. she began to react to painful stimuli and was able to nod her head to answer questions, but was still stuporous and restless, making it difficult to keep her I.V. fluids going. Around 6:00 a.m., the following morning, the intravenous fluids were discontinued and the Dexamethasone was given intramuscularly at six-hour-intervals. This drug was gradually tapered off and discontinued by September 21, 1968.

Laboratory.—Hemoglobin, 12.8 Gm. WBC 27,-600; 15,300; stabs 30; 4; segmented neutrophiles 60; 80; lymphocytes, 8; 16; atypical lymphocytes 2 hematocrit 37%. Urinalysis: Normal. Cephalin floc. 3+; thymol turbidity 9.2.

Chest X-Ray.—Shows some haziness overlying the lung fields associated with increased linear streaking. Otherwise, the heart, great vessels and mediastinal structures are within normal limits. The diaphragms appear to be elevated.

Viral Studies.—Studies done at the West Virginia Department of Health, Hygienic Laboratory Division, were reported on November 12, 1968, as follows: CAM EGG inoculation run to check for viable virus present in spinal fluid, resulted in no pox visible on membrane. The same test for virus present in suspension of crust from vaccination resulted also in no pox visible on membrane. Further results were reported on November 15: No virus has been isolated from spinal fluid specimen. Pox virus visualized by Electron Microscopy from crust. Acute and convalescent blood serology tests failed to demonstrate any significant rise in titre.

Twenty hours after admission, the child was fully conscious and able to take oral liquids. She remained very listless for the next three days

and started to run a high fever. On September 18, 1968, her temparature was up to 104 F., rectally. On September 19, 1968, it went up to 105 F. She received oral aspirin and Elixir Phenobarbital every four hours as needed for fever. Her convulsions did not recur. By September 24, 1968, she was afebrile and alert.

Repeated neurological evaluation was essentially within normal limits. Her deep tendon reflexes were present by September 24, 1968, and no apparent sequelae were detected.

She was discharged on September 25, 1968. No medications were prescribed.

Final Clinical Diagnosis.—Smallpox vaccine encephalomyelitis.

The child returned to the outpatient clinic on October 9, 1968. She had been back to school and was completely asymptomatic. Re-examination at this time was essentially negative. Her neurological examination was normal.

Discussion.—At stated before, the use of steroids in the treatment of viral diseases has not been recommended by some observers; however, intravenous Dexamethasone has been successfully used in the treatment of children with increased intracranial pressure[7] associated with brain swelling and other acute encephalopathies[8] of obscure etiology. Because of the presence of increased intracranial pressure in this case and of the high mortality rate associated with this condition, steroid therapy was thought of and Dexamethasone started. The drug was given slowly and repeated only after clinical improvement was evident. Secondary bacterial complications were feared when this child became extremely listless and her temperature rose to 105 on her third hospital day; because of the absence of positive physical findings, however, antimicrobial therapy was withheld.

Summary

A six-year-old white female developed acute, severe encephalopathy following a one and one-half day prodromata of fever, headache and vomiting. She had received primary smallpox vaccination 18 days previously. On admission to the hospital the patient had severe clonic convulsions and increased intracranial pressure.

She was treated with intravenous Dexamethasone and her response was dramatic. She was discharged 10 days after admission with no apparent sequelae. Generic and trade names of drugs:

Dexamethasone	Decadron, Deronial, Gammacorten
Amobarbital Sodium	Amytal Sodium

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The shortest distance between two points of view is a detour.

Diplomats' Aphorism

Special Article

The Physician's Assistant

Hu C. Myers, M. D.

There have always been physician's assistants. Doctors, like all other people who accomplish much, must have people about them who can and will help them in many ways, else their productivity (in terms of service) never becomes large. Throughout the years, their assistants have ranged from untrained people doing menial work about the office, through trained aides, to nurses and young physicians. The medical technologist and the x-ray technologist were among the first to be trained directly for the purpose of assisting physicians—the pathologist and the radiologist. The graduate nurse who had been given additional training in office procedures and who assisted the physician in the hospital and the surgeon in the operating room was considered by many to be the ideal assistant for the generalist, the internist or the surgeon.

The essence of the problem relating to assistants for the doctor has, therefore, never been "will he have them?" but "how good will they be?" It has always been "will they have only menial duties?" or "will they be intelligent, and will they be educated to function in a role which will free the physician from time-consuming tasks which should not require the depth of thought which he himself has developed over a long period of education and research?" "Will he be free to use his ability and his knowledge for advanced and meaningful aid to people who are sick? Or will his work largely be routine minor decisions, treatments and explanations which could be done by someone having less theoretical knowledge and perhaps a more practical approach?"

For a long time, it has been recognized that neither the nursing nor the medical profession has the numerical strength to furnish doctors the assistants that they need. Medical assistants were being trained in increasing numbers and had become most proficient in assisting the physician in numerous ways. However, the increasing complexities of medical care had left a gap which could be filled only by a person who had the scientific background, the philosophical approach and the understanding of the ethics of the physician himself if the assistant were to assume some of the lessor and time-consuming tasks which are still being required of the average physician.

The Author

- **Hu C. Myers, M. D., Director, Physician's Assistant Program, Alderson-Broaddus College, Philippi, W. Va.**

First Program at Duke

The physician's assistant concept had been thought of by many people, but it remained for Dr. Eugene Stead[1] of the Duke University Medical Center to establish the first program for the education of such a professional. This program was started as a two-year program for corpsmen from the Armed Forces who had had extensive experience in medical care. Doctor Stead was aided by many people, especially by Dr. Harvey Estes and Dr. Robert Howard.

About the same time that the Duke program was developing, a four-year degree program was being considered at Alderson-Broaddus College. This program was to be primarily for young men and women just out of high school, although former corpsmen of the Armed Forces also were to be admitted.

The philosophy pervading the two programs was basically similar, but I can speak only for the one which was developed at Alderson- Broaddus. The aim of this program was to bring to the side of the physician, an assistant who would have breadth of education encompassing enough of the liberal arts to make him a well-rounded individual and one who would be capable of adjusting to the numerous problems of present day life. It would also have enough depth of education in the medical sciences to give him an understanding of the art, the science, and the philosophical and ethical principles of medicine which, hopefully, would help him to apply his knowledge in such as way as to be acceptable to physicians and to the public. Throughout

the course, from the name "Physician's Assistant," to the climactic senior seminar, the student would be taught principles befitting his role as an assistant, rather than as an independent practitioner. Those students who found such a role unacceptable for any reason were encouraged to change their majors.

Philosophy Underlying A-B Program

The story of the development of the Alderson-Broaddus program has been reported elsewhere.[2] The basic philosophy underlying the formation of the program included the following general principles:

1. The seeking of high school graduates with intelligence, scientific interest, honesty, integrity and service motivations.

2. The planning of a curriculum which would balance the liberal arts with the medical sciences of anatomy, physiology, biochemistry, pharmacology, pathology, microbiology, biomedical physics, medicine and surgery. Introductory courses in the major medical and surgical specialties as well as an overview of the history, philosophy and ethics of medicine were considered essential and were included.

3. Clinical experience to reinforce the didactic portions of the curriculum was to be started in the third quarter of the first year.

An attempt was made to structure the curriculum in such a manner that principles and not merely technique were stressed. Time to mature was considered a valuable biproduct of the four-year course.

Advisory Committee

The program has now been in operation one school year. It is rapidly gaining the support of the members of the medical profession as well as the members of the various allied health groups. The program is under constant scrutiny of an advisory council composed of the President of the College, the Academic Dean, the Chairman of the Division of Professional Studies, the heads of the Departments of the Natural Sciences and the Division of Social Studies, the Director and two members of the faculty of the Department of Nursing, the Executive Director of the West Virginia State Nurses Association, the President of the Board of Trustees of the College, the Administrator of Broaddus Hospital as well as the Medical Director and a member of the medical staff, the Provost and the Professor of Medicine of the West Virginia University School of Medicine, and five members of the West Virginia State Medical Association.

The program is young, and it is undergoing revision when change seems to be necessary. Problems are being identified and solutions to them are being sought. We have found some problems which have been difficult, but so far have not found any which have defied solution. Student acceptance has been good. We feel that such an educational program will assist in bringing quality medicine to more people and may prove to be part of the answer to the disparity between the manpower which is available for modern medical care and that which can be delivered by the limited number of physicians and allied health professionals that are currently available.

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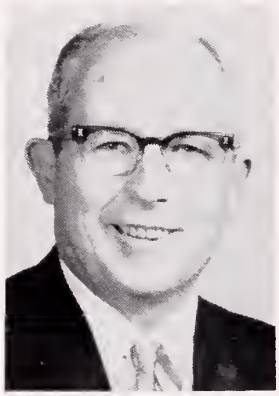

A message from . . .

The President

THE YEAR AHEAD

FIRST, I want to thank you for your confidence in me in making me your new President. I will do my best to serve you and the interests of medicine in the State for the coming year.

To do this I will need help, guidance and suggestions from all of you. I hope you will feel free to contact either me or our Charleston office at any time. We will need your advice and consultation in the months ahead.

What do we face ahead? These are some of the problems:

We probably will have increasing pressure put upon us to keep the cost of health care down. We will need to be alert so that the physician will not be made the scapegoat of a constantly rising economy and a bureaucratic monster.

Efforts to bring new physicians and to keep our own graduates in the State will also be demanded. We hope to have an active contact with the students now in school, either through a committee or through area groups. The newly created Joint Council on Teaching Hospitals and the enthusiasm of the Auxiliary should also help us along these lines.

Our relationship with the Medical Center needs to be improved. This is a two-way street, and the quicker we widen the avenue the better it will be for everyone. We need to think not only in the realm of public relations, but also in the ever increasing realm of postgraduate education.

These are a few of the problems that confront us, but again, I would ask your help and welcome your suggestions and criticisms.

Maynard P. Pride MD

MAYNARD P. PRIDE, M. D., *President*

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EDITORIALS

HISTORY REPEATS ITSELF

Just two short years ago your humble correspondent had the pleasure of penning an editorial concerning the interesting career of Dr. Charles A. Hoffman, who, at that time, had just assumed the Presidency of the American Urological Association, the first West Virginian so honored.

As presented in simple and direct fashion, that editorial clearly defined our distinguished colleague as a man of complex nature and ability, combined with a personal charisma possessed by few medical men—talents which are put to full use by even fewer of our colleagues.

Carl Hoffman is indeed a remarkable individual, who, through determination and experience, has earned the esteem and respect of his fellow physicians over the entire nation, and it comes as no surprise that he was elected to membership on the Board of Trustees of the American Medical Association at its recent annual meeting in New York City. Even though his candidacy was announced only a short time before the annual meeting an inexorable ground swell of approbation rapidly developed and his election ensued by a comfortable margin over another very able candidate. To those of our readers who are actively interested in, and cognizant of national medical matters, this honor is well deserved.

Carl Hoffman's stature, his personal integrity, and his dedication to service, combined with a willingness to work, will be put to full and beneficial use on the Board of Trustees with ensuing benefit to all organized medicine.

The basket which could hide his light has not as yet been woven.

C. A. Hoffman, M. D.
Member, AMA Board of Trustees

The application of all these talents could well lead to further upward progress on the hierarchical ladder, and ultimate selection for the highest level of responsibility and honor in organized medicine.

I hope I'm around to record that event.—JSK

---

100 YEARS AGO

One hundred years ago this September courses in medical subjects were given for the first time in West Virginia University by a man who had the degree of doctor of medicine. The University was actually founded in 1867, but was called "The Agricultural College of West Virginia." In 1869 the name was legally changed to West Virginia University, and in the school year 1869-1870 a course was given in anatomy, physiology and hygiene by a distinguished physician and surgeon, Hugh Workman Brock, M. D., of Morgantown. His title in the University catalog was "Lecturer in Anatomy, Physiology and Hygiene." Doctor Brock was a graduate of Jefferson Medical College of Philadelphia, and was recognized as one of the outstanding physicians in the State. He served the University on a part-time basis for 13 years and died at the comparatively early age of 52.

Doctor Brock's appointment was the beginning of a continuous program in the teaching of anatomy and physiology by a series of men who held the degree, doctor of medicine. In point of fact, since that time—100 years ago—there has always been at least one man on the University faculty who had the M. D. degree. West Virginia University can well be proud of this fine record.

Between 1869 and 1902 the medical courses had several titles; in 1902 they were called "The College of Medicine." In July 1902 John Nathan Simpson, M. D., a graduate of Johns Hopkins University, was appointed as Instructor of Anatomy and Physiology in the University. He was a native West Virginian, having been born in the town of Mason. During his first year as a teacher in the University he organized what in essence was the first two years of medical curriculum. The enrollment between the years 1902 and 1912 was rather small and erratic; it ranged from 6 to 30 entering students; the average entering class was about 15. In 1920 the enrollment increased and continued to do so until 1934.

In 1912 the curriculum was slightly changed and in that year the Board of Regents established "The School of Medicine"; it was considered as a coordinate College of the University. Doctor Simpson was made Dean of the School.

Dean Simpson retired in June 1935 at the age of 66. Edward J. Van Liere, Professor of Physiology, who had taken his M. D. degree at the Harvard Medical School, was made Acting Dean on July 1. Two years later he was made Dean of the School. The School of Medicine was reorganized so as to meet the requirements of the accrediting agencies, and among other things the entering class was reduced to 31 students.

In March 1951 the Legislature passed a bill for the creation of a four-year medical school (also a school of dentistry and a school of nursing). The Basic Sciences Building, which in essence housed the basic medical sciences, the school of dentistry, the school of nursing and the school of pharmacy was completed in the spring of 1957, and on July 1, 1957 the School of Medicine moved into the building. The entering class was enlarged. The 522-bed University Hospital was completed in 1960 and the first M. D. degrees were conferred on 15 students in June 1962.

Doctor Van Liere retired from the deanship in December 1960, and Clark K. Sleeth, a native West Virginian, who had taken his M. D. degree at the University of Chicago, and who had served as Assistant to the Dean for several years, was made Dean of the School on January 1, 1961. The School continued its rapid growth and presently 75 first-year medical students are accepted.

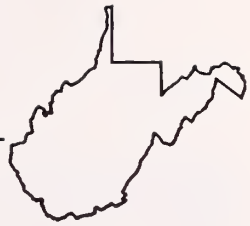
The citizens of West Virginia are to be commended for their foresight in establishing not only a four-year medical curriculum, but also a School of Dentistry and a School of Nursing (the School of Pharmacy had been established previously.) The entire complex is known as the Medical Center. This past school year there were approximately 1,000 students enrolled in the Medical Center, all working toward a degree.

RURAL HEALTH CONFERENCE

The 22nd Rural Health Conference, sponsored annually by the West Virginia State Medical Association, will be held at Jackson's Mill on Thursday, October 2. It is anticipated that more than 300 persons will be in attendance at the one-day Conference.

Dr. Martha J. Coyner, Chairman of the Rural Health Committee and also a member of the Rural Health Council of the AMA, along with the members of the Advisory Committee, deserve much credit for once again arranging a most interesting program which is outlined elsewhere in this issue of *The Journal*. It is evident that the annual conferences rank high among the important and successful programs sponsored by the State Medical Association.

GENERAL NEWS



Dr. C. A. Hoffman Elected To AMA Trustee Board

Dr. C. A. (Carl) Hoffman of Huntington has been elected to the Board of Trustees of the American Medical Association, becoming the first West Virginian in a quarter century to serve on that important body.

C. A. Hoffman, M. D.

The election of Doctor Hoffman, a Past President of the West Virginia State Medical Association, came on July 17, the final day of the AMA's Annual Convention in New York City. Elected for a three-year term, he succeeds Dr. Edward R. Annis of Miami, Florida, who did not seek re-election.

Members of the AMA House of Delegates chose Doctor Hoffman over Dr. Henry I. Fineberg of New York City in a secret ballot. Although the vote count was not announced in the House, it was learned that Doctor Hoffman defeated Doctor Fineberg, Executive Vice President of the Medical Society of the State of New York, by a vote of 146 to 80.

Doctor Hoffman has been a member of the AMA House of Delegates since 1958 and Vice Chairman of the Council on Medical Service for the past year. As a trustee, he will relinquish both positions.

Doctor Hoffman's successful campaign was led by Dr. Frank J. Holroyd of Princeton, another AMA Delegate. Many West Virginia physicians from Huntington and elsewhere attended the AMA meeting and supported Doctor Hoffman's candidacy.

The Huntington urologist had been a candidate for Vice Speaker of the AMA House of Delegates. However, about three weeks before the AMA Convention a series of developments prompted Doctor Hoffman to comply with the urging of many friends to submit himself as a candidate for trustee instead.

Not since 1945 has the West Virginia State Medical Association been privileged to have a representative on the AMA Board of Trusteees. In that year, the late Dr. James R. Bloss, also of Huntington, completed a decade of service on the Board.

The New Trustee

Doctor Hoffman has risen to positions of leadership in virtually every organization with which he has been connected.

He has served both the Cabell County Medical Society and the West Virginia State Medical Association as President, and for several years he has chaired the State Association's Insurance Committee.

He was President of the Mid-Atlantic Section of the American Urological Association in the 1950s, and during 1967-68, he served as President of the national AUA organization. At the present time he serves as President of the American Association of Clinical Urologists and Secretary of the Board of Directors of the National Association of Blue Shield Plans.

Doctor Hoffman has been a member of the West Virginia Medical Licensing Board for the past four years. He is a Past President of the Huntington Y.M.C.A., the Rotary Club of Huntington and the Huntington Chamber of Commerce.

He brings to the AMA Board of Trustees vast experience and knowledge in the field of health insurance.

A native of Ironton, Ohio, Doctor Hoffman is a Fellow of the American College of Surgeons and the International College of Surgeons and is a Diplomate of the American Board of Urology and the International Board of Urology.

Other New AMA Officers

As far as West Virginia physicians attending the meeting were concerned, the election of Doctor Hoffman was the high point of the five-day meeting. However, several other officers were elected on the final day.

Dr. Walter C. Bornemeier of Chicago, Speaker of the House of Delegates, was named President Elect of the AMA without opposition. Next year he will succeed Dr. Gerald D. Dorman of New York City, who was installed as President on July 16.

Dr. Russell B. Roth of Erie, Pennsylvania, was promoted from Vice Speaker to Speaker of the House, also without opposition. Succeeding Doctor Roth as Vice Speaker is Dr. J. Frank Walker of Atlanta, Georgia, who won election in a four-way contest.

Elected Vice President of the AMA was Dr. Louise Gloeckner of Pennsylvania.

Re-elected to the Board of Trustees without opposition were Drs. Burt L. Davis of Palo Alto, California; Burtis E. Montgomery of Harrisburg, Illinois; and Max H. Parrott of Portland, Oregon.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1969:

Cabell

Abella, Domingo ..... Wayne
Dorsey, Eugene Richard ..... Durham, N. C.
Gabatin, Jose Q. ..... Huntington
Gilbert, Gary G. ..... "
Pena, Rogelio G. ..... Barboursville
Ratcliff, Gilbert A., Jr. ..... Huntington
Sheils, John P. ..... "
Tolley, Gary M. ..... "
Turner, Charles E. ..... "
Vega, Elmer T. ..... "

Eastern Panhandle

Den, Alfred ..... Martinsburg
Novosad, Charles L., Jr. ..... Healdton, Okla.
Samuels, Norman ..... Martinsburg
Wanger, William H. ..... "

Fayette

Iturriaga, Segundo Carlos ..... Montgomery

Harrison

Palmer, Louis C. ..... Bridgeport
Patton, Paul B. ..... Clarksburg
Suess, John F. ..... Lost Creek
Williamson, Walter E., Jr. ..... Clarksburg

Kanawha

Ali, Ahmed ..... Ripley
Bate, Mostafa H. ..... Indianapolis, Ind.
Klapproth, Karl L. ..... Charleston
Pauig, Pablo M. ..... "
Pushkin, Jack ..... "
Rashid, Richard C. ..... South Charleston
Thompson, Wayman J., Jr. ..... Charleston

Logan

Capua, Anacleto ..... Logan
Martinez, Manuel ..... "
Soyangco, Alfredo L. ..... "

Marion

Cox, Jack E. ..... Farmington
Coyner, John L. ..... Fairmont
Koppel, Donald M. ..... "
Tallman, Terry T. ..... "
Turner, John C. ..... "

Marshall

Anwar, M. F. ..... Moundsville
Parilla, P. V. ..... Cameron
Vincent, Alfred James ..... Glen Dale

Mason

Bernadez, Nonita V. ..... Pt. Pleasant
Obregon, Pedro J. ..... "

Mingo

Carter, William H. ..... Williamson
de Valle, Rodrigo V. ..... "

Monongalia

Chamberlain, C. Richard, Jr. ..... Morgantown
Dickenson, Donald C. ..... "
Fakadej, A. V. ..... "
Kelley, John Fredric ..... "
Lapp, Norman Leroy ..... "
Sales, Avelino T. ..... "
Trick, O. Lee ..... "

Ohio

Armstrong, Robert B. ..... Wheeling
Imperio, Ephraim C. ..... "
McMurray, J. Thomas ..... "
Richey, Drake ..... Canton, Ohio

Parkersburg Academy

Santiago, Q. S. ..... Parkersburg

Potomac Valley

Friera, Esteban ..... Romney

Raleigh

Alfonso, Jose G. ..... Beckley
Barnes, James A. ..... "
Oyco, Jose L. ..... "

Tygart's Valley

Erinc, A. I. ..... Elkins
Santibanez, Samuel M. ..... Grafton

Wyoming

Fontana, Norberto A. ..... Oceana

10th Cardiovascular Symposium In Williamsburg, Va.

The 10th Annual Cardiovascular Symposium will be held September 5-7 at Williamsburg Lodge in Williamsburg, Virginia. The program is sponsored by the Council on Clinical Cardiology of the American Heart Association and the Tidewater Heart Association in cooperation with the Peninsula Heart Association.

Dr. Denton A. Cooley of the Baylor University College of Medicine will be one of the featured speakers on Friday, September 5. He will discuss "Clinical Application of Heart Transplantation."

Other speakers on Friday will include Dr. Arthur M. Vineberg of Royal Victoria Hospital in Montreal and Dr. Richard R. Lower of the Medical College of Virginia in Richmond.

Presenting papers on Saturday will be Dr. David Richardson of the Medical College of Virginia, Dr. Henry Wagner of Baltimore, Dr. Thomas Killip, III, of Cornell University Medical College, and Dr. Adrian Kantrowitz of Maimonides Hospital in Brooklyn.

Sunday speakers will be Dr. Jerome W. Conn of the University of Michigan Medical School, Dr. David Kritchevsky of the University of Pennsylvania, Dr. Robert S. Eliot of the University of Florida and Dr. Frank A. Elliot of Pennsylvania Hospital in Philadelphia.

MPH Degree Programs Offered In California

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley has announced a series of postgraduate programs for pediatricians, obstetricians and other physicians interested in receiving training in the field of maternal and child health.

These programs lead to the degree of Master of Public Health, and tax-exempt fellowship support is available.

Courses and descriptions are as follows:

"Maternal and Child Health"—A nine-month program in planning, organizing and operating comprehensive health services for mothers and children.

"Family Planning"—A nine-month academic program providing intensive work in family planning as part of the general graduate preparation of maternal and child health specialists.

"School Health"—A nine-month academic program providing intensive work in school health as part of the general graduate preparation of maternal and child health specialists.

"The Multiply Handicapped and Mentally Retarded Child"—A 21-month academic and clinical program in planning, organizing, and operating community services for children with multiple handicaps, including mental retardation.

"Career Development Programs"—Three-year academic and residency programs consisting of one year of academic training leading to the degree of Master of Public Health combined with residency training in pediatrics or obstetrics and gynecology.

Applications are now being accepted for groups entering in July or September of 1970. Information may be obtained by writing to Dr. Helen M. Wallace, School of Public Health, University of California, Berkeley, California 94720.

Hospital Pharmacy Seminar At WVU, September 18

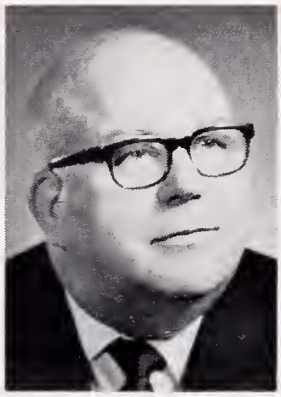
A Symposium on Pharmacy Services in Hospitals will be held at the West Virginia University Medical Center in Morgantown on September 18. Sponsors include the Medical Center, the West Virginia State Medical Association, the West Virginia Hospital Association, the West Virginia Nurses Association and the West Virginia Pharmaceutical Association.

Among the speakers will be Dr. Richard V. Lynch, Jr., of Morgantown, Assistant Professor of Medicine at WVU and a Past President of the West Virginia State Medical Association. Doctor Lynch's subject will be "Physician-Pharmacist Relations—A Physician's View."

Other speakers will include Mr. William R. Huff of Charleston, Executive Vice President of the Hospital Association, and Dr. R. O. Bachmann of Morgantown, Dean of the School of Pharmacy at WVU.

Dr. R. E Flood Appointed To Licensing Board

Gov. Arch A. Moore, Jr., appointed Dr. Richard E. Flood of Weirton to a five-year term on the Medical Licensing Board of West Virginia.



Richard E. Flood, M. D.

Ross E. Newman, M. D.

Doctor Flood, a Past President of the West Virginia State Medical Association, succeeds Dr. William P. Bittinger of Oak Hill, whose term expired.

The Governor also reappointed Dr. Ross E. Newman of Beckley to the MLB.

Holdover MLB members include Drs. Frank J. Holroyd of Princeton, D. E. Greeneltch of Wheeling, Dudley C. Ashton of Beckley, Thomas G. Reed of Charleston, C. A. Hoffman of Huntington, and Maynard P. Pride of Morgantown. Dr. N. H. Dyer, State Health Director, serves as Secretary ex officio.

Continuing Education Program At MCV, 1969-70

The 41st Annual McGuire Lecture Series will be held at the Medical College of Virginia in Richmond, October 23-24.

The topic of this year's program will be "Dermatology." The McGuire Lecturer will be Dr. Eugene J. Van Scott, Professor of Dermatology at Temple University School of Medicine in Philadelphia.

MCV also announced four other programs for the coming year.

The Annual Meeting of the Southern Society for Pediatric Research will be held November 21-22.

December 10-12 are the dates for the Ware Residence Program. Dr. Roy Parker, Professor and Chairman of the Department of Obstetrics and Gynecology at the Duke University School of Medicine will be the Visiting Professor.

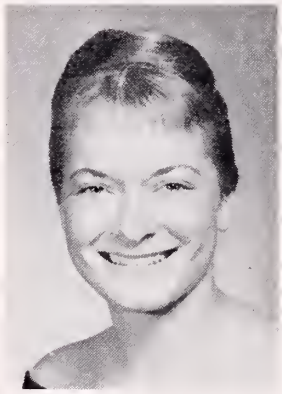
The Law Institute on Hospitals and Medicine will be held February 6, 1970, and the 23rd Annual Stoneburner Lecture Series will be conducted February 19-20.

Additional information about any of these programs may be obtained by writing to: Department of Continuing Education, School of Medicine, Medical College of Virginia, Richmond, Virginia 23219.

22nd Annual Rural Health Conference At Jackson's Mill on Oct. 2

The 22nd Annual Rural Health Conference will be held at Jackson's Mill on Thursday, October 2, and more than 300 persons are expected to attend the one-day meeting. The Conference is open to members of all interested groups and an invitation to attend the meeting is being extended to members of local farm bureaus, home demonstration councils, agricultural extension workers and personnel of local health departments.

Hu C. Myers, M. D.



Lauralee Sherwood, D. V. M.

The Conference is sponsored annually by the West Virginia State Medical Association in cooperation with the West Virginia Home Demonstration Council, the Cooperative Extension Service of West Virginia University, the State Department of Health and the West Virginia Farm Bureau.

Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee of the State Medical Association, will call the meeting to order in the Assembly Hall promptly at 10:00 A. M. The invocation will be given by Dr. Stanley H. Martin, President of West Virginia Wesleyan College.

Doctor Coyner announced that the first speaker at the morning session will be Dr. James H. Walker of Charleston. Doctor Walker, whose specialty is thoracic surgery, will discuss "Medical Quackery."

The next speaker will be Dr. Hu C. Myers of Philippi, Director of the Physician's Assistant Program at Alderson-Broaddus College. The program has been in operation for one year and Doctor Myers will give a progress report on the unique course which leads to a degree following four years of study.

The final portion of the morning program will be devoted to a program on "Who Helps with Health?" Participants will be senior students from the Department of Nursing at West Virginia Wesleyan College. The students have been involved in a program to explore how rural health in West Virginia may be improved through the efforts of the well-informed health worker. The study was based on the fact that a knowledge of community resources can lead to greater utilization of health services.

Ample time will be allotted for a question and answer period with active audience participation.

Luncheon will be served in the Mt. Vernon Dining Room at 12:15 P. M. with the West Virginia State Medical Association as host.

Afternoon Session

Mr. Maynard P. Pride of Morgantown, President of the State Medical Association, will deliver the address of welcome at the opening of the afternoon session.

The first speaker at the afternoon session will be Lauralee Sherwood, D. V. M., Instructor in Physiology and Bio-Physics and Instructor in Public Health and Preventive Medicine at the West Virginia University Medical Center. Doctor Sherwood will speak on the timely subject of "Prevention of Rabies."

The remainder of the afternoon session will be devoted to a progress report on a number of projects which have been implemented recently by the State Department of Health. Dr. N. H. Dyer, State Director of Health, will serve as moderator, and brief reports will be presented by staff members in charge of the programs.

Advisory Committee

The program for the Conference was planned by members of the Advisory Committee to the State Medical Association's Rural Health Committee. In addition to Doctor Coyner, the other members are Miss Mildred E. Fizer, State Chairman, 4-H and Youth Development Programs and Women's Extension Education Program; Mrs. Ancil Peterson of Horner, President of the West Virginia Home Demonstration Council; Miss Gertrude Humphreys of Morgantown, former State Extension Home Demonstration Leader; Dr. N. H. Dyer, State Director of Health; and Mr. E. O. Gregory of Buckhannon, Secretary of the West Virginia Farm Bureau.

New Membership Category Set Up By ACP

The American College of Physicians has established a new category of membership for young physicians who are in the midst of their graduate medical education.

The category will be known as "candidate membership." It will be available to young men who have completed at least two years of postdoctoral training in internal medicine or a related specialty, or as a medical officer of the armed services or of the U. S. Public Health Service.

These members will have all privileges of membership except the right to vote or hold office. There will be no automatic advancement to regular membership, and candidate membership will be terminated one year following the date on which the man becomes eligible for regular membership.

Applications for candidate membership may be obtained by writing to: Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Black Lung Conference In Kentucky

Twenty-three famous experts in lung diseases will meet in Kentucky this month to identify needed research in coal workers' pneumoconiosis (CWP).

Specialists in pathology, epidemiology, diagnosis and evaluation, and physiology from England, Germany, Canada and the United States will confer September 10-12 in a closed session to seek agreement as to the key medical problems associated with CWP and to structure an integrated research approach to such problems.

The conference is being sponsored by Spindletop Research, Inc., a private, non-profit research firm. There will be an open meeting on Saturday, September 13 to allow the conference team to discuss the conference results with fellow medical researchers and physicians, attorneys and others with a professional interest in CWP.

The open session will be held at Spindletop's research facilities near Lexington, Kentucky.

Information about the open session should be addressed to: Spindletop Research, Inc., P. O. Box 481, Lexington, Kentucky 40504.

ACP Elects 2 State Men

Drs. Preston C. Davis of Beckley and William H. Jacobs of Clarksburg were elected to Associate Membership in the American College of Physicians on April 20.

Psychiatric Hospital Opens New Services Addition

The Saint Albans Psychiatric Hospital in Radford, Virginia, dedicated its new $750,000 services addition on July 11.

The new facility includes offices and waiting room space, consultation rooms, a 200-seat dining room, kitchen, two-lane bowling alley and 12 additional patient beds.

Dr. James P. King, Medical Director of the Hospital, and Federal Judge Ted Dalton spoke at the dedication ceremonies, attended by about 150 guests. Judge Dalton praised the staff and the hospital for their contribution in the mental health field, pointing out the establishment of six outpatient clinics in West Virginia, Virginia and Tennessee.

Saint Albans Psychiatric Hospital was established in 1916 by the late Dr. John C. King. The non-profit facility has 162 beds.

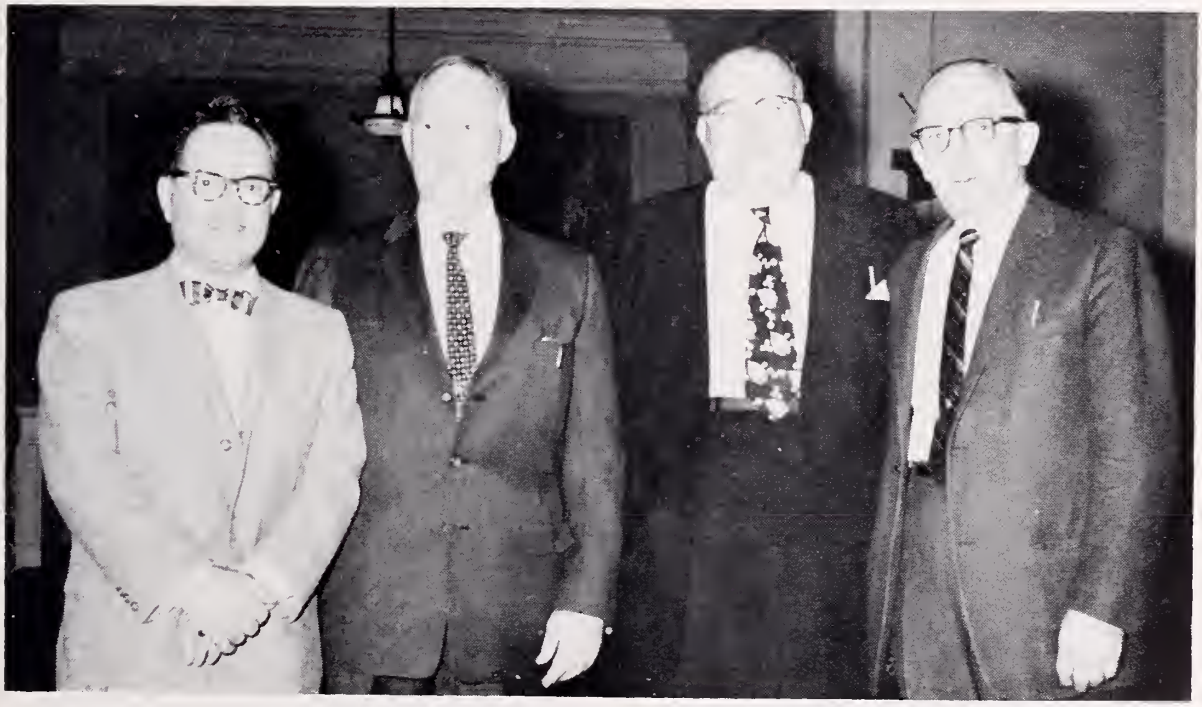
Family Planning Film Available

Contraceptive methods are reviewed for hospitalized postpartum women in a film now available through the Planned Parenthood Federation. "Happy Family Planning" was produced under a grant from Wyeth Laboratories.

The eight-minute film is in color and is available in 16 mm. and 8 mm.

The film is designed for showing to lay groups, especially hospitalized women in the immediate postpartum period. Prints can be purchased at cost through the Planned Parenthood Federation, 15 Madison Avenue, New York City, New York 10022.

Looking Back 10 Years . . .



These physicians were elected new members of the Council of the State Medical Association in 1959. They are (left to right): Dr. Albert C. Esposito of Huntington; Dr. Clyde A. Smith of Beckley; Dr. Richard E. Flood of Weirton; and Dr. J. C. Pickett of Morgantown. Doctors Esposito and Flood later served as President of the Association.

Waste Disposal Problem Is Explained

As our country becomes more urbanized, industrialized and the population continues to soar, environmental problems become of greater significance according to the State Health Department. For several years, we have dealt with problems caused by the misuse of the environment and have battled the devastating effects of unwise agricultural practices and strip mining operations. Now we must be even more concerned with problems of pollution, crowding, noise and waste disposal.

Regardless of what the environmental problem may be, it is essentially a concern for man—for his total health, happiness and well-being. All too often our pursuits for economic efficiency, modern transportation and unprecedented building expansion overlook the total well-being of the citizen, in addition to leaving a trail of environmental problems.

As published in a recent issue of "State of the State's Health," Dr. N. H. Dyer, State Director of Health, pointed out that in West Virginia for two and one-half years, the Solid Waste Program of the State Health Department has been concerned with the disposal of solid wastes.

The four major sources of solid wastes are urban (domestic, commercial and municipal), industrial, agricultural and mineral. According to recent United States Public Health Service figures, every year we discard more than 190 million tons of garbage, trash, bottles, cans and other refuse. This is just urban solid wastes. Including industrial, commercial and agricultural wastes, the figure climbs to nearly 3.5 billion tons. In West Virginia alone an average of 3.2 pounds per day per person of household waste is generated.

Nationwide, collection and disposal of garbage and other solid waste cost an estimated $4.5 billion annually, and yet the methods used have improved little over the past 25 years.

While collection methods need to be improved, the most pressing need is for regulated disposal sites. In West Virginia as in other states, the most common method used for garbage disposal is the open dump which creates a breeding ground for rats, insects and vermin and constitutes a major health problem. The availability of space for the "city dump" is gradually decreasing as the suburbs move farther and farther out. Consequently, the health hazards from the open dump increases as dumps are located nearer residental areas. As an alternative, our out-of-the-way sites of natural beauty are being used which results in the pollution of land, water and air.

Current recommended means of disposal are incineration, sanitary landfill and composting.

Incineration is a costly process. Charleston is the only city or municipality in the State that has an incinerator. Approximately 80 percent of the material is burned, leaving 20 percent ash, much of which is still putrescible. An incinerator can accept only that part of a community's waste which is combustible, leaving the remainder to be disposed of by some other means.

The sanitary landfill is a method used by many of the largest cities in the United States. It is a method that can accept all types of waste. Since it is a method by which all wastes are buried on a daily basis, there are no rats or flies. Ground pollution and ground water pollution are held to a minimum by keeping all buried waste above the natural ground water table and controlling surface water so that it is diverted away from the fills.

Composting is the decomposition of organic matter to a relatively stable material, Doctor Dyer went on to explain. This process has usually been set up to make compost, a peat moss-like humus for sale. However, the process of sorting and grinding is costly, and it is debatable as to whether compost can be profitably marketed because of competitive commercial fertilizers.

The process of composting involves the separation of inorganic wastes such as glass, metals and plastics from the organic matter. The organic material is then ground into particles of uniform size, stacked in rows in the open or revolved in closed drums and allowed to decompose under conditions of aeration. In either method, the waste is exposed to air, intermittently or continuously which prevents production of odor-causing bacteria. When decomposition is complete, it is reground ready for use as a soil additive.

Air pollution and ground water pollution are eliminated by the composting of wastes.

Only one of the many types of waste has been covered in this article. This group of wastes is of primary concern because it represents the greatest potential health hazard. Other wastes of great concern to the public are automobiles, old appliances and debris from demolition. But with these solid wastes, we perhaps must focus our efforts on recycling and utilization rather than actual disposal.

Dr. James S. Klumpp of Huntington (center) celebrated his Golden Wedding Anniversary in June. He is shown here at the Summer meeting of The Council when he made personal acknowledgment of the many expressions of good wishes he and Mrs. Klumpp received from officers and other members of the West Virginia State Medical Association. Doctor Klumpp, a Past President of the Association, has been very active in the organization since his retirement several years ago. He currently serves as an Associate Editor of The West Virginia Medical Journal and as the Association's Parliamentarian. With Doctor Klumpp are Dr. C. A. Hoffman of Huntington (left), also a Past President of the Association, and Dr. Richard W. Corbitt of Parkersburg, whose term as President expired last month.

College of Physicians Lists 1969-70 PG Courses

The 1969-70 schedule of postgraduate courses to be sponsored by the American College of Physicians has been announced by ACP headquarters in Philadelphia.

Tuition fees include $60 for members of the ACP and $100 for nonmembers for each course. Programs and other information may be obtained by writing to: Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Course dates, titles and locations are as follows:

1969

October 1-4—"Vascular Disease," Rochester, Minnesota.

October 8-11—"Medical Oncology Today—An Internist's Guide to Cancer Chemotherapy," Minneapolis, Minnesota.

October 27-31—"Office Psychiatry for Internists," Boston, Massachusetts.

November 3-7—"Mechanisms of Disease and Modern Therapy," Chicago, Illinois.

November 3-7—"Nuclear Medicine: Diagnosis and Treatment of Disease with Radionuclides Given Internally," Ann Arbor, Michigan.

1970

January 2-4—"Medicine and Law," Los Angeles, California.

January 2-6—"Function and Dysfunction of the Gastrointestinal Tract," Miami, Florida.

January 26-29—"Practical Approach to Selected Clinical Problems," New Orleans, Louisiana.

February 23-27—"Gastroenterology for Teachers," Ann Arbor, Michigan.

March 2-4—"Clinical Concepts in Infectious Diseases: Manifestations and Management," Gainesville, Florida.

March 9-13—"Cardiology and Renal Disease: Pathophysiology and Pharmacology," Chicago, Illinois.

March 16-20—"Clinical Problems in Internal Medicine," Cleveland, Ohio.

March 23-26—"Neurology and the Internist," Rochester, Minnesota.

March 30-April 3—"Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment," Ann Arbor, Michigan.

April 9-11—"Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems," Philadelphia, Pennsylvania.

April 23-25—"Recent Advances in Endocrinology and Selected Metabolic Diseases," San Francisco, California.

May 6-8—"A Workshop-Type Symposium on Medical Intensive Care," Vancouver, British Columbia.

May 20-22—"Clinical Aspects of Infectious Diseases," Seattle, Washington.

May 27-29—"Heart Disease—Clinical and Pathological Correlation," Washington, D. C.

June 3-5—"Pathology, Pathologic Physiology and Clinical Aspects of Renal Disease," Washington, D. C.

June 8-12—"Psychiatry and the Internist," Baltimore, Maryland.

June 8-12—"Internal Medicine, 1970—Old Principles —New Practice," Iowa City, Iowa.

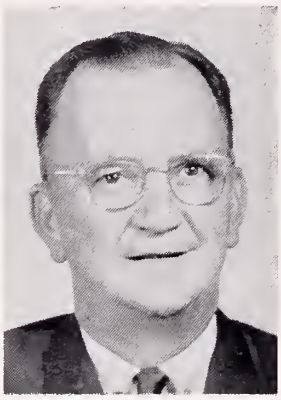
June 15-17—"Cardiac Auscultation," New York City.

June 15-17—"Blood Transfusion Therapy and Related Immunology," East Lansing, Michigan.

Dr. F. L. Blair Appointed To Board of Regents

Dr. F. Lloyd Blair of Parkersburg has been appointed by Gov. Arch A. Moore, Jr., to the new State Board of Regents.

The nine-member Board began functioning on July 1 under an act of the 1969 Legislature. It assumes administrative functions in higher education previously held by the West Virginia University Board of Governors and the State Board of Education.



F. Lloyd Blair, M. D.

West Virginia and Marshall Universities and the State operated colleges come within the Board's jurisdiction.

Initial appointments to the Board were for staggered terms, and Doctor Blair was named to a six-year term.

Doctor Blair, a native of Jackson County, attended West Virginia University and received his M.D. degree from the University of Louisville School of Medicine. He is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.

He is a former Secretary of the Parkersburg Academy of Medicine, and his other professional memberships include the West Virginia State Medical Association and the American Medical Association.

Training in Resuscitation In New Martinsville

A training program in the technique of cardio-pulmonary resuscitation has been conducted in the New Martinsville area under the auspices of the Wetzel County Medical Society and the West Virginia Heart Association.

More than 400 people in the area have been trained in the technique. These include hospital personnel. dentists, police, firemen, life guards, high school students and others.

The program is to be used as a guide for the Heart Association in establishing community life-saving programs throughout the State.

MLB Licenses 38 Physicians To Practice in State

The Medical Licensing Board licensed 38 physicians to practice medicine in West Virginia during meetings of the MLB in Charleston in April and July.

The MLB licensed the following 13 physicians by reciprocity at a Board meeting held at The Capitol in Charleston on April 7, 1969:

Block, John Bradford, Cincinnati, Ohio
Campbell, Earl William, Morgantown
Den, Alfred A. J., Martinsburg
Entress, Cheryl Pixley, Wheeling
Flueck, James Allen, Morgantown

Jarrell, John Percha, Jr., Madison
Manger, Donald Frederick, Philippi
McClung, Hugo Juhling, Madison, Wis.
Metting, Frank Blaine, Spokane, Wash.

Nabers, Horace Alexander, Jr., Parkersburg
Pickhardt, Woodrow Louis, Charleston
Rolston, Theron Rice, Bellaire, Ohio
Sorensen, Alfred Lee, McMurray, Pa.

The following 25 physicians were licensed by reciprocity at an MLB meeting held in Charleston on July 7, 1969:

Avery, Anthony Parke, Morgantown
Byrd, John William, South Charleston
Campbell, James Wilford, Charleston
Canada, Robert Owen, Jr., White Sulphur Springs
Church, Jackie Lee, Charleston

Downey, Regis Fallon, Wheeling
Fiscus, Jane Ann Avery, Parsons
Godwin, Donald Wayne, Parkersburg
Joyce, Thomas Hunt, III, Morgantown
Lett, Paul Edward, Huntington

Machinski, Gerald Thomas, Elkins
Maxson, Ward Willis, Clarksburg
Moore, Freeman Mark, Parkersburg
Morris, Joseph Thomas, Wheeling
Morgan, Karl Harris, Houston, Texas

Ortiz, Peter Raphael, Charleston
Oster, Walter Filmore, Cumberland, Md.
Purkall, James Brennan, Jr., Bluefield
Renn, Joseph John, III, Morgantown
Sabo, Alexander Joseph, Morgantown

Six, Richard Ray, St. Albans
Spencer, Donald Lynn, Glen Dale
Thomas, Frank B., III, Hancock, Md.
Vesano, Jack Lee, Charlotte, N. C.
Walker, William Edward, Ripley

The next meeting of the Medical Licensing Board will be held at The Capitol in Charleston on October 6, 1969, for the purpose of licensing physicians by reciprocity to practice medicine in West Virginia.

Dr. Boetsch Named To Board

Workmen's Compensation Commissioner Fred Davis has announced the appointment of Dr. Carlos Boetsch of Charleston to the Workmen's Compensation Appeal Board, replacing Dr. Edwin C. Neville, who has left the State.

The Board hears all compensation cases involving occupational diseases with the exception of "black lung."

Health Manpower Needs Outlined by WVU

More than 11,000 jobs in the healing arts will be generated in West Virginia during the 1965-75 period, according to a recent estimate.

This is one of the employment projections made in a report published by the West Virginia University Regional Research Institute.

The report, which was prepared by Dr. William H. Miernyk and his colleagues at the WVU Institute, is based on a regional input-output model that is used to simulate economic development.

"On the basis of economic activity in West Virginia in 1965 and the annual rate of economic growth in the nation, we forecast total industrial output for 1975," Doctor Miernyk explained. "By comparing 1965 outputs and employment figures we derived the labor force that will be needed in 1975."

According to the report, the number of new jobs for medical and dental technicians will increase 69 per cent—from 1,535 to 2,602; the number of new openings for physicians and veterinarians will increase 54 per cent—from 1,725 to 2,657; new jobs for nurses will increase 43 per cent—from 7,553 to 10,857; new openings for dentists will increase 20 per cent—from 713 to 856; and the number of new positions for pharmacists will increase 14 per cent—from 588 to 674.

These are new jobs only and do not include the personnel that will be hired during 1965-75 to replace those who leave these professions.

The total demand (new jobs plus replacements) for these professions in West Virginia during 1965-75 are forecast to be: medical and dental technicians—1,662; doctors and veterinarians—1,422; nurses—7,614; dentists —341; and pharmacists—264.

"It would be unwise to suggest that the specific occupational projections made in our study will be exactly realized by 1975. But the trends indicated, and the changing occupational structure of the labor force, can be used as reliable guides for long-term educational planning purposes," Doctor Miernyk said.

Family Medicine Symposium In Georgia, Oct. 6-10

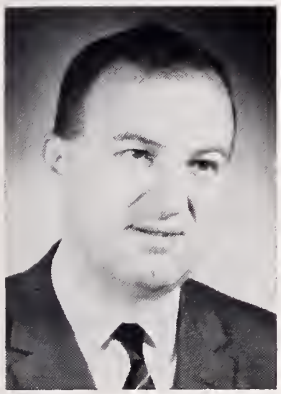
The Annual Family Practice Symposium of the Medical College of Georgia will be presented in Augusta, October 6-10.

In addition to Medical College of Georgia faculty, the following guest faculty will participate: Dr. Lynn P. Carmichael, Director of Family Medicine at the University of Miami School of Medicine; Dr. Amos Johnson of Garland, North Carolina, Past President of the American Academy of General Practice; and Dr. William R. Willard of Lexington, Kentucky, Chairman of the Council on Medical Education of the American Medical Association.

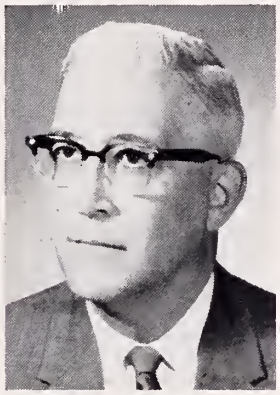
Additional information may be obtained by writing to Dr. Glen E. Garrison, Director of Continuing Education, Medical College of Georgia, Gwinnett at Fifteenth Street, Augusta, Georgia.

Dr. R. V. Lynch To Head Heart Association

Dr. Richard V. Lynch, Jr., of Morgantown, will be installed as President of the West Virginia Heart Association during the organization's Annual Meeting and scientific Sessions in Parkersburg, September 12-13.



Robert J. Marshall, M. D.



Richard V. Lynch, Jr., M. D.

Doctor Lynch, a Past President of the West Virginia State Medical Association and Assistant Professor of Medicine at the West Virginia University Medical Center, will succeed Dr. Robert J. Marshall, also of Morgantown, Professor of Medicine at WVU.

Doctor Marshall will preside at the opening session on Friday, September 12, beginning at 9 A. M.

Subject for the morning scientific session will be "Heart Disease and Children." Dr. Roland Schmidt of Morgantown will present papers on "Audio-Visual Methods of Teaching Pediatric Cardiology" and "Diagnosis and Treatment of Rheumatic Fever in Children." Dr. Carolyn McCue will discuss "Diagnosis of Heart Disease in Children."

Doctor Lynch will preside at the Friday afternoon session, which is to be devoted to "Risk Factors," "Late Complications of Coronary Artery Disease; Recognition and Management," and "Transportation Problems of the Cardiac Patient—The Role of Helicopters and VSTOL in West Virginia." Participating in the discussion of these subjects will be Michael Hunsaker, M. D., Everett C. Carter, Ph.D., Frederick J. Wegmann, Ph.D., and Morris H. O'Dell, M. D.

There will be a non-medical program for laymen attending the meeting. Doctor Schmidt will discuss "Does Your Child Have An Abnormal Heart?" and the question of "Can I Give My Heart Away?" will be explored by Dr. Paul Selby, Dean of the WVU Law School, and L. M. Eckmann, M. D., of South Charleston.

A social hour and the annual membership and awards banquet will be held Friday evening.

Saturday's session will open with a discussion and instructions of the Assembly System of the Heart Association, with Doctor Marshall and P. J. Corbitt, D.D.S., Chairman of the Board, in charge. The General Assembly will follow and will be presided over by Mrs. Seth Savage, Vice Chairman of the Board of Directors.

The keynote address will be given by William Kegan, Vice President Elect of the American Heart Association.

Several panel discussions also will be held Saturday. They will concern Heart Association Regionalization, Heart Association Policy and Local Heart Unit Problems.

The Heart Association's Board of Directors will meet Saturday evening for the Annual Fall Board Meeting and Business Session. Highlight of that meeting will be the election of officers for the coming year.

Physicians wishing to attend the meeting may make their reservations through the West Virginia Heart Association, 211 35th Street, Charleston 25304.

'Medical Education' Is Subject For Essay Contest

"Medical Education in the Years Ahead" will be the subject for this year's Caleb Fiske Prize Essay contest of the Rhode Island Medical Society.

Manuscripts must be typewritten and double-spaced. They should not exceed 10,000 words and must be submitted by December 15, 1969.

A cash prize of $500 is offered for the winning essay.

Additional information about the contest may be obtained by writing to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

Council on Teaching Hospitals To Meet September 18

The third organizational meeting of the West Virginia State Medical and Hospital Associations' Joint Council on Teaching Hospitals will be held at the Holiday Inn in Morgantown on Thursday evening September 18.

Dr. David Z. Morgan of Morgantown, Chairman Pro Tempore of the Council, said the agenda will include the election of officers and discussion of the newly-formed Council's program for the coming year.

There will be a social hour and dinner, to be followed by the meeting, which is to begin at about 7 P. M.

Jefferson Medical College Has New Name

The 145-year-old Jefferson Medical College of Philadelphia has a new name.

Effective July 1, the College became Thomas Jefferson University. The school is divided into a medical college, an allied health sciences college, the graduate studies college, and the hospital, which is now known as Thomas Jefferson University Hospital.

Hospital Association Calls For 'Total Involvement'

Comprehensive health care for all will only be achieved when the providers of health services become totally involved with the people they seek to serve, an editorial in a recent issue of *Hospitals*, Journal of the American Hospital Association, declares.

The AHA editorial points out that the nation's hospitals are being challenged by poor people to use their resources and ability to respond both to health needs and to other social needs.

The entire issue of *Hospitals* is devoted to the delivery of health care services to the poor. Articles explore the need for hospital involvement in delivering those services, and discuss ways in which hospitals can take a leading role in producing the best possible system of comprehensive health care.

According to the editorial, "massive attacks on the nation's health problems" through programs such as Medicare, Medicaid and Regional Medical Programs have "helped those least who need help most."

"White middle-class society still hasn't completed its lesson on social equality of different ethnic groups," the editorial says, "although the providers of governmental service are beginning to realize that the only way to govern peacefully in a democratic society is to ensure involvement of all the groups governed."

The editorial adds: "The lesson to providers of health care is the same—involvement. Only by involvement of and with all recipients of care and all who need care can we actually accomplish comprehensive care. And adequate involvement cannot be achieved by any system, health or otherwise, that fails to see its relationship to the totality of its community—the spiritual, financial and social elements as well as the health elements."

Department of Human Genetics Created at Columbia

Columbia University has created a Department of Human Genetics and Development, centering on a rapidly growing field of scientific investigation which has far-reaching implications for the future.

The establishment of the new department in the Faculty of Medicine at Columbia's College of Physicians and Surgeons was announced by Dr. Andrew W. Cordier, Acting President of the University.

The new department will institute a broad program of instruction, research, and related patient services in the areas of human genetics, development, and human reproductive biology. Dr. Paul A. Marks, Chairman of the new department, said:

"Investigations in these areas hold out the prospects for effective approaches to correct or prevent the undesirable effects of certain genetically determined abnormalities; for early detection, prevention, or possible therapy in birth defects; for reduction in infant mortality, maternal mortality and stillbirths; and for effective approaches to the wide-ranging number of diseases in which genetic factors or hereditary material play a role, including cancer and even the aging process."

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Sept. 4-6—Maryland Medical (Semiannual), Baltimore.
Sept. 4-6—Am. Assn. of Ob-Gyn., Hot Springs, Va.
Sept. 14-20—Col. of Am. Path., Chicago.
Sept. 23-25—Ky. Medical, Louisville.
Sept. 26-Oct. 3—AAGP, Philadelphia.

Oct. 2—Rural Health Conf., Jackson's Mill.
Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 20-21—W. Va. Hosp. Assn., White Sulphur Springs.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.
Oct. 31-Nov. 2—Pot.-Shen. Val. PG Inst., Martinsburg.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.

Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.

May 5-9—Am. Psychiatric Assn., San Francisco.
May 11-14—Am. Urological Assn., Philadelphia.
May 18-22—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.

June 21-25—AMA, Chicago.

July 17-18—Rocky Mtn. Cancer Conf., Denver.

The West Virginia Medical Journal

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The Status of Medicine in West Virginia Today*

Richard W. Corbitt, M. D.

Doctor Pride, officers and members of the West Virginia State Medical Association, members of the Woman's Auxiliary, distinguished guests, ladies and gentlemen:

Since we last met one year ago, the duties of this office have brought me into close touch with the many, many problems confronting our profession. Consequently my presidential report could ramble on and on, but in the interest of your time and your personal comfort, I shall discuss but a few of the matters of concern to us as doctors.

My remarks will be divided into two parts—a review of my year-long stewardship, and a glance at what we might expect in the next decade.

This, then, is "The Status of Medicine in West Virginia Today" as I see it.

My term as your President has been one of the most interesting and fulfilling experiences of my life. I have enjoyed doing the job. And I can say that I have to the best of my ability carried out the duties and responsibilities of the office which you entrusted to me.

Behind every President there are many faithful people who give generously of their time and effort. First and foremost, I want to thank my wife Margaret for bearing with me. She has traveled over the State to many county society meetings which I attended. She has been a great inspiration and a great help to me.

Secondly, I would like to thank the members of the West Virginia State Medical Association for the privilege of serving as President. At county society meetings over the State, I have been received warmly by the members. Without exception the hospitality was magnificent.

Thirdly, I want to thank members of our Headquarters Office staff for their cooperation, kindness and fine work: Mr. William H. Lively, our Executive Secretary; his assistant, Mr. Edward D. Hagan; the office manager, Mrs. Mary Hamilton; and the fourth member of the staff, Mrs. Marilyn R. Reno.

Relationship with Medical Students

I believe one of the more significant developments of the past year has been the cementing of relationships with the medical students at West Virginia University through the Student American Medical Association chapter there. Several months ago, SAMA asked us to provide a series of speakers who would discuss the various aspects of medical practice in West Virginia. We thought this was a wonderful idea, and the program was started late in 1968. The following members of our Association graciously gave of their time to participate: Dr. Maynard P. Pride, who soon will become your new President; Dr. George F. Evans, the esteemed Editor of our *Journal;* Dr. A. J. Villani of Welch; and Dr. Samuel Henson, one of our scholarship recipients who now ministers to the health needs of the good people of the Hurricane area of Putnam County. And I also enjoyed the privilege of addressing these fine young men and women. I believe this program has been worthwhile and should be continued.

The Author

- **Richard W. Corbitt, M. D., Immediate Past President of the West Virginia State Medical Association.**

*Annual Address of the President, West Virginia State Medical Association, 102nd Annual Meeting, The Greenbrier, White Sulphur Springs, August 23, 1969.

Good Committees Are Important

Much of the work of Associations such as ours is done by hard-working committees headed by competent chairmen. For Dr. Pat A. Tuckwiller and his Committee on Medical Education and Hospitals, this has been another banner year. This Committee has been instrumental in the establishment of the Joint Council on Teaching Hospitals. It will be the aim of this Council to maintain and improve graduate medical education programs in West Virginia. The Medical Education Committee also has been in close touch with the new Physician's Assistant Training Program, which soon will begin its second year at Alderson-Broaddus College. Also, our Medical Education Committee now has a subcommittee to study the new standards of the Joint Commission on Accreditation of Hospitals. This subcommittee has been in touch with hospital medical staffs regarding the activities of JCAH in their areas.

In the thorny field of Medical Economics, all of us owe gratitude to Dr. Harry S. Weeks, the Chairman of the Medical Economics Committee, and to Dr. George R. Callender, Jr., Vice President of the Association. They and the committee have worked diligently to improve the medical economics climate in West Virginia. Great strides have been made toward improving our relationships with the State Department of Welfare and the Workmen's Compensation Fund. Both of these state agencies are now headed by competent, reasonable men.

Peer Review

The Medical Economics Committee is also our liaison with the Medicare Program. All of you know that questions have been raised nationally as to the cost of this vast program. Many physicians who have large Medicare caseloads and thus have large Medicare billings have come under the suspicious eye of the Federal Government. We believe that much of this criticism is completely unjustified. At the same time we realize that a few rotten apples are to be found in virtually every barrel. A very small minority can cause trouble for the entire profession. And for that reason, every county medical society should establish a "peer program" to handle these complaints on the local level.

You have witnessed the scientific program. So you know what a great job Dr. Jack Stark and his Program Committee did in lining up the speakers for this 102nd Annual Meeting. And the Woman's Auxiliary is to be complimented on its arrangement of the social program.

Dr. Martha J. Coyner holds two important offices. She chairs our Committee on Medical Scholarships and our Rural Health Committee. Those of you who know Martha are aware of the good work of her and her committees. This past spring, Martha and her Medical Scholarships Committee selected two more promising young men to receive the Association's four-year scholarships to the West Virginia University School of Medicine. Another successful Rural Health Conference was held at Jackson's Mill last October under the auspices of Doctor Coyner's Rural Health Committee. More than 375 persons attended the Conference.

The 60-day session of the Legislature early in the year kept Dr. Frank J. Holroyd's Legislative Committee very active. The Committee studied several bills this year, and I think we had a very good legislative record again.

Although other committees have not been very active this year, they were ready to serve if called upon and as they have done in the past.

Dr. Hoffman Elected AMA Trustee

Incidentally, Doctor Holroyd played a key role in one of the banner events of the year as far as the leadership of your Association is concerned. All of you know that Dr. Carl Hoffman of Huntington last month was elected to the Board of Trustees of the American Medical Association, becoming the first West Virginian to sit on the Board in about 20 years. Doctor Holroyd was Doctor Hoffman's campaign manager, and he engineered a decisive 146 to 80 victory over a New York doctor.

Earlier, we announced Carl's candidacy for Vice Speaker of the AMA House of Delegates. However, just three weeks before the AMA meeting, Dr. Edward R. Annis announced he would not be a candidate for re-election to the Board. Carl and others in our State Association began receiving calls and letters from influential physicians throughout the country urging him to seek Doctor Annis' seat on the Board. After in-depth evaluation of the situation, we decided to offer Carl as a candidate for the Board instead. We had an excellent candidate in Carl Hoffman. We had an able campaign manager in Frank Holroyd. And we had a remarkable display of teamwork on Carl's behalf on the part of the doctors attending the AMA meeting. With all this on our side, we were confident of the ultimate result.

Many, many West Virginia doctors had a hand in this victory. Physicians from all over the State responded to our plea for help by contacting their friends in other states urging Carl's election. Carl is most grateful for this assist, and I would like at this point to add my

thanks to all West Virginia physicians who had a part—however small—in helping elect our capable colleague to such an important position in the AMA.

WESPAC

The WESPAC organization has been very active this year under the chairmanship of Dr. Frank J. Holroyd and Mrs. Charles L. Goodhand. I have recommended to the county societies that they include in their annual billings on a voluntary basis, the WESPAC contribution. This has been done in many societies and has been a great success even in a non-election year. Voluntary billing should be encouraged in all societies. Also, special thanks to Mrs. Pat A. Tuckwiller, the Secretary-Treasurer.

Compliments to the Auxiliary

The Woman's Auxiliary under the leadership of Mrs. John A. B. Holt, as usual deserves compliments for a job well done. Especially worthy of mention is the Auxiliary's help in encouraging young physicians to practice medicine in West Virginia. This project must continue to have the highest priority.

Another enjoyable aspect of my year as your President was my visit to the State Association meetings of our neighboring states. In Kentucky, Ohio, Pennsylvania and Maryland, we were treated royally. It was interesting to note that many of the problems we have here in West Virginia are shared by these sister state associations.

Medicine Under Fire

Now, a few words about the status of medicine today:

We doctors are a rugged lot. Very few segments of American Society suffer more criticism than we do. Yet, we are still here—keeping the healthy healthy and helping the sick get well. We are physicians in a free society, and as such we believe in the usual and customary fee for service, whether the payor be the private patient or a government third-party.

We are accused of inflating the cost of health care. But I need not remind you that doctors are not responsible for increased hospital charges. And I submit that examination would reveal that increases in physicians fees are in line with increases in the cost of living.

Our position on Medicare continues to draw criticism from some quarters. We opposed Medicare because it provided subsidy for the very rich as well as the very poor and we still object to this situation. It must be emphasized again that the medical profession of America was never opposed to care of the needy. But the profession predicted accurately the staggering cost of the implementation of the Medicare and Medicaid Programs.

Title XIX Ill-Conceived

We regarded and continue to regard the Title XIX Medicaid Program as an ill-conceived mess. The states were given a virtually open invitation to dip into federal funds for the care of almost any category of patients they chose to include.

The principal medical problem in this country today is how to provide total health care at the lowest possible cost to not just the rich . . . not just the poor . . . but to all Americans. The problem is complex and no one has the complete answer. The answer will not be found merely in hiring legions of health professionals and having them go forth into neighborhood health centers. I believe that there is a definite relationship between the so-called health problem and illiteracy, illegitimacy, alcoholism, drug addiction, improper housing, inadequate food and diet and economic instability. Nutritional anemia, for example, is certainly not the result of improper health care.

Additional Government Interference

There is no doubt that the so-called health planners are still agitating for further governmental regimentation of medicine. We can counteract these moves only with a united front. In the past, I regret to say, too few doctors have involved themselves in the fight to maintain the concept of private medical practice as we have known it. We must be prepared to offer workable, reasonable alternatives when these silly notions come flying in our faces from the desks of the bureaucrats.

Our health care system should be locally oriented to meet the needs of each particular locale. We as doctors should take an interest in these programs and participate on a local basis in community or regional health planning.

Each community has its own health care problems, and area planning is still in infancy. There have been very few applications of planning throughout the country, and most planning agencies are in the process of developing programs. Organized medicine approves and supports health planning with voluntary community initiative at the local level.

Physician Shortage Continues

Another area of concern continues to be our shortage of physicians. I can assure you that your State Medical Association has been active

in trying to find more physicians to come to West Virginia. Our Headquarters Office has been trying to match interested out-of-state physicians with areas in which their services could be put to good use. This program has had some measure of success, but we still need many more doctors. Through the work of the Joint Council on Teaching Hospitals and through our speaking program at WVU—both of which I have discussed—we hope to be able, eventually, to keep more West Virginia trained doctors in West Virginia.

It is not easy to lure doctors to West Virginia. They are interested in good schools for their children, recreational facilities and cultural activities. These are things which the communities must provide.

Until we manage to attract a suitable number of doctors to our State, we must encourage the growth of the allied health professions. At the present time, there are about 13 allied health personnel to each physician, and it is estimated that this will increase to a ratio of 25 to 1 within the next five years. The growth in the allied professions has been rather rapid in recent years, and many colleges and universities have been setting up training programs for nurses, physicians' assistants and the like. This will ease the burden on the doctor, freeing him of much routine so that he can deal with the more complex problems of his patients. I believe this is an important aspect of providing good health care.

United Profession Can Meet Challenges of Future

In conclusion, let me leave you one personal thought. I believe that a free medical profession —well organized and believing in the principles of a free profession and fee for service—can cope with the problems that will face us in the next decade. But those of us who tend toward complacency must shed that attitude or we will be licked. The American Medical Association and the West Virginia State Medical Association will provide leadership and assistance. But in the final analysis it will be individual doctors—people like you and I—who will determine the fate of our noble profession.

Thank you for the high privilege of serving you.

To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal will* receive individual and immediate attention.

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Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Coronary Arteriography*

Harvey G. Kemp, M. D., and Richard Gorlin, M. D.

Opacification of the coronary vascular system by contrast material during cardiac catheterization has had an enormous impact on our knowledge of coronary heart disease. It has allowed us, with surprising safety, to define precisely the anatomic extent of coronary atherosclerosis in living man. Added impetus has been given to coronary arteriography by new directions in therapy. For example, there is accummulating evidence that surgical revascularization of the myocardium is not only feasible but beneficial. The normal course of a recently developed diagnostic procedure, like a new drug, is to oscillate between crests of over-enthusiasm and nadirs of total rejection. Now, after some 10 years, it is useful to reassess the place of coronary arteriography in the diagnostic armamentarium.

Because this article is intended to give a general view of the field to the practicing internist, surgeon, and general practitioner, relatively little attention will be given to the technical details of obtaining high quality coronary arteriography. It will be repeatedly stressed, however, that only high quality studies provide the accurate information which justifies exposing the patient to the potential hazards of the procedure.

Historical Account

The two methods which have received widest application are the retrograde approach from the right brachial artery and the percutaneous retrograde approach from the femoral artery using a pre-formed catheter. In experienced hands, either of these methods can yield excellent selective studies, at low risk to the patient.

Safety

The decision to perform coronary arteriography should be based upon the weighing of the benefits expected to accrue from the resulting information, as opposed to the potential hazards involved. The latter have recently been evaluated in a cooperative study of 16 laboratories. A total of 3,312 studies performed on 3,264 patients were included in the study group. Sixty-six complications occurred in 62 patients, for an overall complication rate of 1.9 per cent. Cardiac complications occurred in 10: myocardial infarction in 5, coronary insufficiency in 4, and dissection of a coronary arterial wall without myocardial infarction in 1. Death occurred in two of the five patients sustaining a myocardial infarction. One of these patients had an aortic valve replacement with a Starr-Edwards prosthesis, and the infarction was secondary to coronary embolism. An additional death occurred in a patient with combined coronary heart disease and aortic stenosis, yielding an overall mortality rate of less than 0.1 per cent. Ventricular fibrillation occurred in 27 patients: it was found to be a more frequent complication in women, and occurred oftener after injection of the right than the left coronary artery. In each instance, the patient recovered without sequellae, indicating the relatively innocuous nature of this arrhythmia when well-trained personnel and adequate resuscitative equipment are available. Thrombosis of the brachial artery occurred in 10 patients, but in the present author's experience, this probably underestimates this complication. Fortunately if the brachial artery remains patent above the antecubital space, symptoms are slight and transient, and surgical repair is not necessary. However, surgical intervention has been necessary in about 0.5 per cent (2 of over 400) patients in the author's experience. In both instances, surgery restored the patency of the brachial artery.

It seems reasonable to conclude from available data that the risk of death related to coronary arteriography is related to the severity of the coronary heart disease, and that significant aortic stenosis or prosthetic replacement of the aortic valve add to that risk. On the other hand, the vast majority of patients undergoing this procedure have extensive coronary disease and with-

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***Prepared by the West Virginia Heart Association for publication in The West Virginia Medical Journal.**

stand the arteriographic study with no complication at all.

Indications

It is somewhat easier to quantify the potential hazards associated with coronary arteriography than to assess the potential benefit to the individual patient obtained from the information yielded by the procedure.

It is safe to generalize that the physician caring for a patient is always better equipped to do so when his knowledge of the patient's condition is extended. This is particularly true of diseases in which there is relatively poor correlation between symptoms, indirect measurements, and the extent of anatomic disease. In this regard, several specific observations about coronary heart disease have emphasized the usefulness of arteriography. Studies in the past based solely on autopsy material had shown an excellent correlation between a clinical history of angina pectoris and extensive coronary atherosclerosis. Since the advent of coronary arteriography, however, a group of patients has emerged with angina pectoris but whose major coronary arteries are free of intraluminal obstruction. The incidence of this paradoxical syndrome has been consistently reported to be about 10 per cent of subjects referred to centers performing coronary arteriography because of angina pectoris. The etiology of angina in this group remains obscure, but it would seem probable that the appropriate treatment and prognosis of this group will prove to be significantly different from their counterparts with arteriographically demonstrable coronary atherosclerosis. At present, there are no methods other than arteriography to differentiate these two groups.

In addition to the unusual syndrome just described, there are many patients with less typical histories, with non-specific electrocardiographic abnormalities, with unexplained congestive heart failure, arrhythmia or some combination of the above, in whom coronary heart disease is suspected but cannot be included or excluded on clinical grounds alone. An unknown, but certainly high, percentage of these patients will have normal coronary arteriograms and treatment can be redirected, either toward correction of whatever disease is found, or, in the absence of demonstrable heart disease, toward psychologic rehabilitation. The amount of psychologic damage done to patients by well-intentioned physicians who have erroneously attached the label of coronary heart disease to some masquerading symptom complex, can neither be overestimated nor readily undone.

Perhaps the largest group of patients who merit coronary arteriographic studies includes those who have clearly established coronary heart disease associated with chest pain syndromes not easily controlled by medical management. It is obvious that several value judgments are called for in including the individual patient in this group, and that probably no two observers would consistently evaluate the same patient in exactly the same fashion. Also, it is clear that while the results of myocardial revascularization are being more precisely defined in terms of pain relief, objective signs of increased myocardial perfusion, and longevity, our criteria for study will continue to change. Although it is not within the scope of this report to critically evaluate the status of myocardial revascularization, the threshold for a decision to obtain arteriographic studies is inextricably related to one's evaluation of the benefits potentially available through surgical intervention. Addressing ourselves to this specific point, the authors believe that present data strongly indicate that not only can pain syndrones be substantially relieved by internal mammary artery implantation, but that there is objective evidence of improved myocardial perfusion and further that there is reason for optimism concerning improvement in longevity, particularly in patients surviving 18 months after the procedure. In addition, new revascularization procedures, particularly the direct replacement of segments of the right coronary artery with venous grafts, currently show promise. As surgical procedures have continued to evolve, young patients with myocardial infarction without pain or congestive heart failure have become legitimate subjects for arteriography, at least in centers where data concerning the affect of revascularization on longevity are being actively accrued and evaluated. For the present, it seems unwise and overly conservative to allow patients to severely restrict their lives because of coronary heart disease, and this is particularly true of the young patient.

There are a number of miscellaneous indications for coronary arteriography. Patients with angina and aortic valve disease being considered for valvular replacement should certainly be studied and probably patients with mitral valve disease as well. This enables the cardiologist to better understand total myocardial function and make a more objective estimate of surgical risk and ultimate prognosis. It provides very helpful information for the surgeons who will be perfusing the coronaries at the time of surgery. Uncommon specific indications for coronary

arteriography include suspected congenital malformations, luetic involvement of the coronary ostia, and coronary artery embolism.

To some degree, the indication for adding selective coronary arteriography to any retrograde left heart catheterization procedure performed on a patient in the coronary age group depends upon the ease with which the particular laboratory can perform coronary arteriography. If experienced personnel are available, it can add very helpful information at a negligible additional risk to the patient. Left heart catheterization of a patient with suspected cardiomyopathy is an excellent case in point.

Accuracy of Coronary Arteriography

Every diagnostic procedure must be evaluated in the light of the accuracy of the information it yields. When one views coronary arteriography of excellent radiographic quality, a highly accurate picture of the major coronary vessels and their branches has been obtained. A study comparing the interpretation of coronary arteriography with the actual amount of disease found at necropsy done on 29 subjects at the Peter Bent Brigham Hospital confirmed this impression. Of the many opportunities for error in interpreting 145 coronary arteries individually, only three errors of functional significance were made. There was a direct relationship between the accuracy of interpretation and the radiographic quality of the arteriography, significant errors being made only in films of borderline quality.

A number of factors contribute to radiographic quality, most of which are of a technical nature and are not germane to the present discussion. It is sufficient to remember that appropriate magnification, contrast, focus, and day-to-day consistency are essential and most often found in a laboratory with a high degree of interest in and almost daily use of coronary arteriography.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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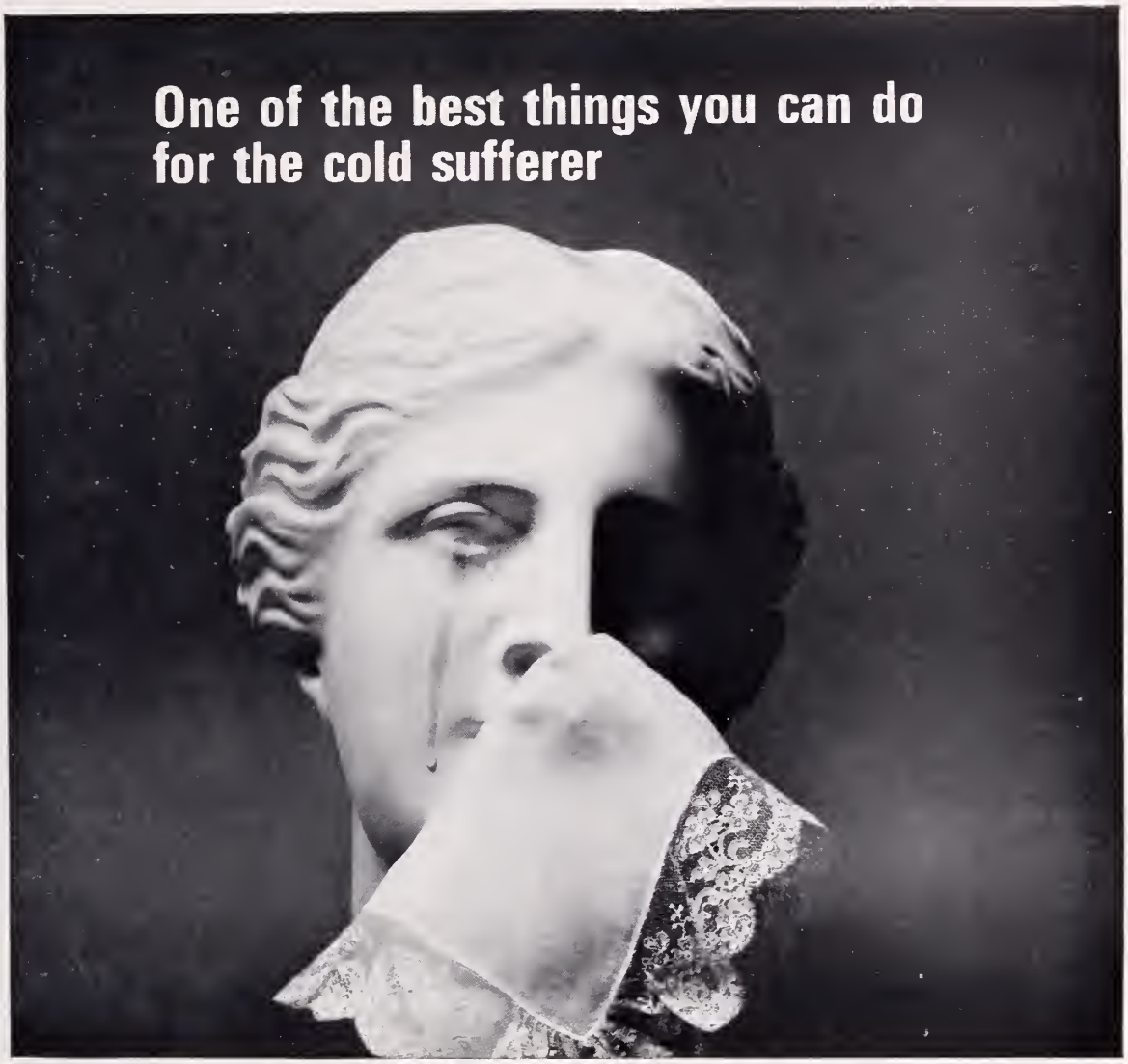

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Giant Villous Adenoma of the Rectum With Severe Electrolyte Imbalance

John M Cook, M. D., and John C. MacLennan, M. D.

When the occasional medical author breaks into print, he usually justifies his "series of one case" by stating either (1) the condition is extremely rare or (2) the condition is more common than is generally appreciated. Villous adenoma with electrolyte depletion formerly has been in the first category and has been reported only since 1954 by McKitterick and Wheelock.[1] According to Soloman, Moran and Nabseth,[2] only 34 cases in which villous adenoma caused severe electrolyte disturbances have been reported. Recently, reports of this type of depleting adenoma have been appearing in the literature more frequently.[3-10]

The purpose of this paper is to report a case of a giant villous adenoma treated in a small hospital.

Case Report

A 70-year-old maiden lady presented herself because of weakness and vomiting. Four days before admission she had developed dull epigastric pain and complained of several loose bowel movements.

Examination revealed a 70-year-old white female who appeared dehydrated and older than her stated age. She was scarcely able to sit up in bed. The abdomen was soft and flat. There was a soft ill-defined mass in the rectum which came to the anal margin. There were mucus and feces dribbling from the anal margin. The legs were tender anteriorly.

Laboratory: White blood cell count was 11,250, hemoglobin 14.6 Gm. and hematocrit 42.5 vol. per cent. Serum amylase 257. There was considerable pus in the urine. CO_2 capacity was 26 mEq., chlorides 94 mEq., potassium 3 mEq., sodium 137 mEq. per liter. Three days after admission, serum calcium was 7.5 mg. per cent, CO_2 capacity 32 mEq., chlorides were down to 88.9 mEq., phosphorus 5.25 mg. per cent, potassium 3.3 mEq., sodium 135 mEq. Hematocrit rose to 44 vol. per cent. Two weeks after admission calcium was 8.5 mg., chlorides 85.5 mEq., potassium 2.7 mEq., and sodium 126 mEq.

Submitted to the Publication Committee, April 21, 1969.

The Authors

- **John M. Cook, M. D., and John C. MacLennan, M. D., Oak Hill, Ohio.**

Hospital course: Because of epigastric distress and elevated serum amylase, special effort was made to study the upper gastrointestinal tract. It was obvious from her laboratory reports that she was being depleted rapidly of electrolytes, especially of potassium. Nine days after admission, sigmoidoscopic examination revealed a huge villous tumor involving almost the entire rectum. The biopsy report stated that this was a benign villous adenoma. Two weeks after admission, following correction of electrolyte imbalance, adominoperineal resection was performed. The adenoma measured 10 cm. by 9 cm. Five units of blood were required during surgery and postoperatively. The postoperative course was essentially uneventful.

The patient was soon eating well and she had good function of her colostomy. The electrolytes soon returned to normal levels. She was discharged a month after admission with the perineal wound not yet healed. She developed some ankle edema at home. When she was examined five months after surgery, the perineal wound had healed and the ankle edema no longer was present. She had returned to her normal weight and strength.

Discussion

Schnitka[9] has shown that potassium concentration in rectal fluid averages 12.2 times the concentration in serum. Roy and Ellis[10] measured secretions from the surface of two villous tumors which contained 54 mEq. and 90 mEq. of potassium, respectively. Sodium and chloride levels also were high. If a tumor with great secretory activity is situated near the lower end of the alimentary tract, there probably would not be opportunity for the secreted electrolytes to be reabsorbed. It is conceivable that smaller villous adenomas high in the intestinal tract could

secrete great quantities of electrolytes without causing symptoms.

These lesions, as in the present case, often are not immediately diagnosed because of the extremely soft character of the tumor which usually is covered with feces and mucus, obscuring the interpretation of digital examination. Most cases reviewed by Davis[3] were palpable on rectal examination. Most authors referred to herein agree that the best treatment of villous adenoma with electrolyte loss is correction of the electrolyte imbalance and then removal of the tumor by fairly complete excision. Most of the pathological reports of the complete tumor have indicated no malignant change (although some have reported malignant degeneration in areas).

It is apparent that even though this is a benign tumor the patient could die of electrolyte depletion if surgical treatment is not performed under the proper conditions. Davis[3] reports five fatalities in 22 known cases.

Summary

Giant villous adenomas of the rectum and sigmoid colon may be associated with profound fluid and electrolyte imbalance. Hypokalemia is the most frequent reported type of electrolyte depletion. Prompt correction of electrolyte imbalance and removal of the tumor are indicated.

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The Physician and Cigarette Smoking

As an apostle of health, the cigarette smoking physician is, indeed, in a paradoxical position. All doctors agree that cigarette smoking is a health hazard. About two-thirds of previously smoking physicians have abandoned it. The other third have developed some remarkable rationalizations, such as: (a) you have to die sometime anyway, or (b) the proof consists of mere statistics, or (c) my grandfather's brother lived to be 100 years old, even though he smoked since the age of 14, or (d) I know a 70-year-old woman who died of a carcinoma of the lung although she never smoked, or (e) I'm hooked, so let's laugh it off!

At its December 1968 meeting, our AMA House of Delegates resolved that, "The AMA again urge its members to play a major role against cigarette smoking." And later, a resolution was passed to the effect that, "the AMA must take a firm stand against smoking by every means at its command."

Every time a physician, in the presence of a patient, puffs on a cigarette he is supporting the "do as I say, not as I do" thesis. He becomes permissive, by example, of a notorious health-destructive hazard. It may be possible to gloss it over by a flip comment or by a clownish joke, but the fact remains that he is encouraging a menace to human health. The AMA knows it, the public knows it, and the cigarette smoking doctor knows it.—*The Journal of the Medical Society of New Jersey.*

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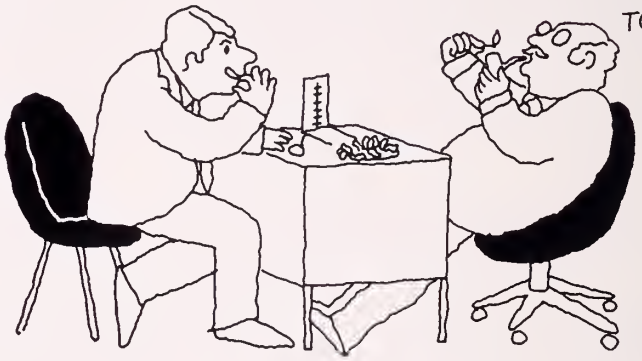

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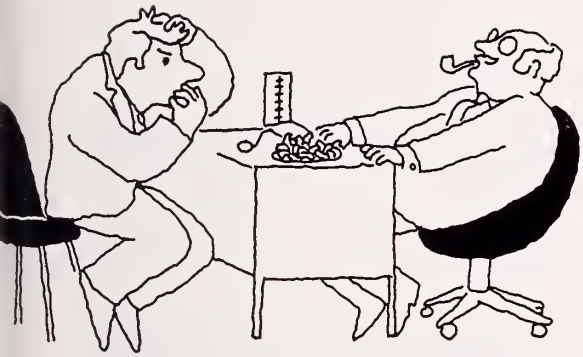

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Electrocardiogram of the Month

Electrocardiographic Changes in Subarachnoid Hemorrhage

Edward K. Chung, M.D., and Edwin J. Morgan, M.D.

SUBARACHNOID hemorrhage can produce a variety of cardiovascular disturbances including a rising blood pressure and a slow pulse rate.[1] In addition various types of arrhythmias have been reported as well as rather specific electrocardiographic changes. The purpose of this paper is to report a case which demonstrates these changes, and to discuss their practical implications.

The Authors

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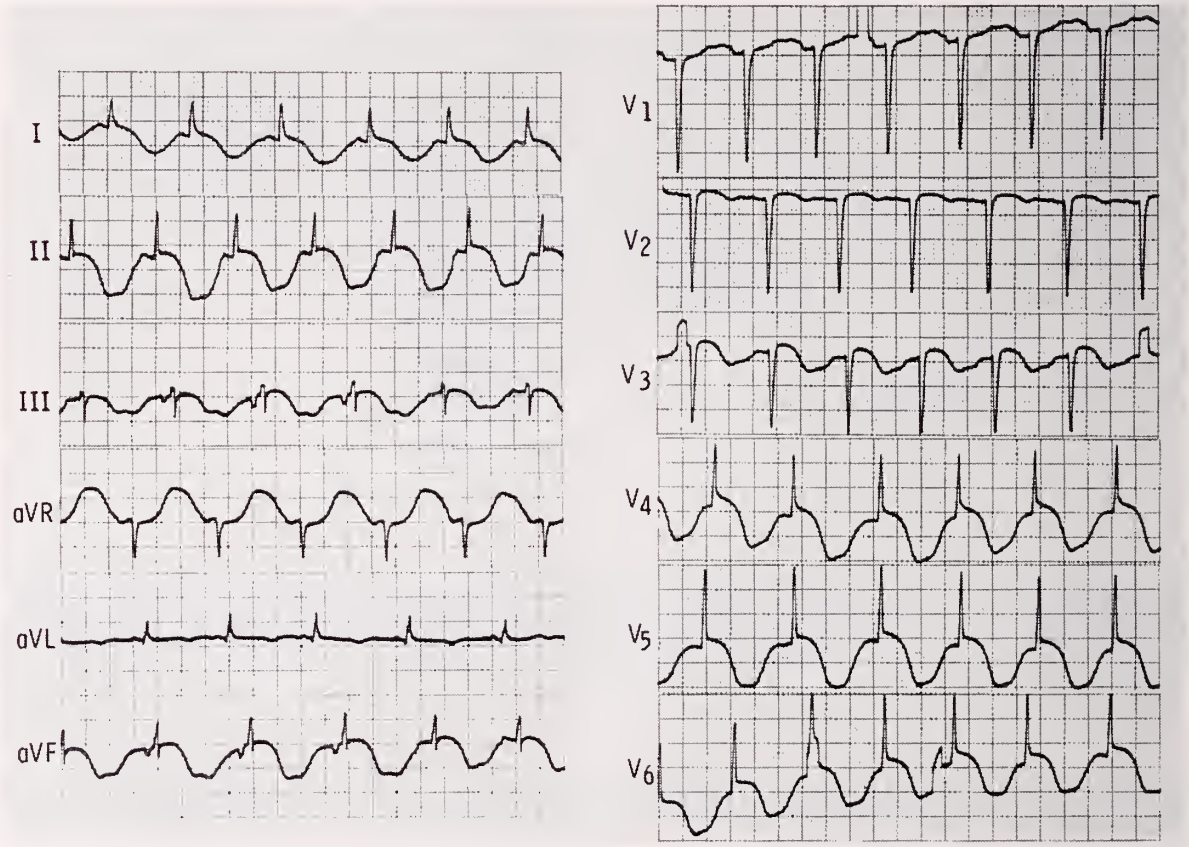

Figure 1

Case Report

Mrs. B. S., a 41-year-old-female was admitted to West Virginia University Hospital via the emergency room on May 12, 1969, with the history of sudden onset of severe occipital headaches about seven days prior to admission. She was taking a shower at the time and had sudden lancinating pain which radiated to the top of her head and behind her eyes. She fell to the ground dazed unable to move, but did not actually lose

consciousness. She was helped to her feet by her son who noted that she was able to talk, but was confused and very unsteady on her feet. Admission to her local hospital was arranged immediately where she was given analgesics with supportive care and normal skull films were obtained. Her symptoms gradually subsided over about three days, and she was then transferred to West Virginia University Hospital for a neurosurgical evaluation.

On physical examination she was alert and oriented with mild photophobia. She was afebrile with normal vital signs. The only abnormal physical sign was moderate nuchal ridity.

Her initial laboratory studies included a normal CBC, BUN, glucose, serum electrolytes and urinalysis. In addition, she had a normal chest and skull films. Lumbar puncture done shortly after admission showed xanthochromia and cerebrospinal fluid pressure of 330 mm. H_2O with 15,000 RBC's/cu. mm. Carotid arteriograms showed a large bilateral middle cerebral aneurysms and shortly after she developed a left hemiparesis, became apneic and unconscious. Resuscitation was temporarily successful, but her condition deteriorated and she expired before surgery could be attempted. An electrocardiogram (Figure 1) obtained shortly after admission showed the typical changes associated with subarachnoid hemorrhage (diffusely inverted T waves with markedly prolonged Q-T interval: 0.60 second). In addition, wandering atrial pacemaker between sinus and A-V node was noted in this tracing. Because of low R waves in leads V_{1-3} old antero-septal myocardial infarction was not entirely excluded.

Discussion

In 1953 Levine[2] described a 69-year-old woman with a subarachnoid hemorrhage whose electrocardiogram showed widespread diffuse T wave inversion and later S-T segment elevation in leads V_5-V_6. Autopsy showed a ruptured aneurysm in the circle of Willis. Since then there have been numerous case reports of the electrocardiographic changes seen in association with subarachnoid hemorrhage.

The changes which may be seen include S-T segment elevation, T wave changes, Q-T interval changes, prominent U waves and various supraventricular arrhythmias including atrial fibrillation with ventricular slowing.[3] S-T, T wave changes suggestive of ischemia are said to occur in about 40 per cent of subarachnoid hemorrhages.[4] Recently Greenhoot and Reichenbach have reported 6 autopsied cases of subarachnoid hemorrhage with a variety of acute and chronic pathological changes in the myocardium. These pathological changes were verified via electronmicroscopy and correlated well with ST-T wave changes suggestive of ischemia and/or subendocardial injury. These lesions seemed most severe adjacent to intra-myocardial necrosis which is due to release of catecholamines from adrenergic nerve endings in the heart.[5] Other factors which have been proposed to explain these electrocardiographic changes are: hypokalemia[6] and lesions involving "area 13" on the orbital surface of the frontal lobes.[4] It is important to note that although a large variety of electrocardiographic changes suggestive of myocardial ischemia have been described in subarachnoid hemorrhage, pathological Q waves have not been reported. This may be helpful in differentiating the electrocardiographic changes associated with myocardial infarction from those associated with subarachnoid hemorrhage. Unfortunately SGOT and CPK estimations are of limited value in resolving this dilemma.[7] Coincident chronic lung disease, coronary and/or hypertensive heart disease makes the problem even more complex, because anoxia whether central nervous system injury, pulmonary or coronary insufficiency may produce ischemia S-T, T wave changes.

Summary

1. A case of subarachnoid hemorrhage associated with diffuse S-T, T wave changes is reported.
2. The precise reason for these electrocardiographic changes is unknown, but some of the possible factors have been discussed.
3. The occurence of electrocardiographic changes in association with subarachnoid hemorrhage is of practical importance, because such changes may simulate those of myocardial infarction or ischemia.

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A message from . . .

The President

OFF TO A GOOD START

Our 102nd Annual Meeting must be rated as one of the best. After the tragic rains and floods of the first day we were blessed with good weather and attendance. The scientific sessions, as well as the Exhibits, continued to draw large numbers throughout the Convention. To Jack Stark and his Program Committee—congratulations for a job well done.

As usual, Bill, Ed, and Mary kept things going like clockwork. An especial thanks to all of them.

The highlight of the program was the appearance of Governor Moore, who was delayed by bad weather. He received enthusiastic support for his vivid presentation of the needs of the State and his plans for improvement.

Commissioners Fred Davis and Edwin Flowers presented an excellent report of the reorganization of their departments. These were well received at the Council meeting and everyone felt that cooperation between the State and the Association concerning medical care was rapidly improving.

I was pleased to have as my first duty as President the honor of speaking briefly to the freshman class at the West Virginia University School of Medicine. I welcomed them as they started into the medical profession and offered them the help of all of you who have preceded them. I believe that if we can keep up the early contact, both at school and in their home areas, we will be more likely to keep them interested in staying in West Virginia.

So, if you know any of them, drop them a line occasionally. You never know what might influence them to stay in our great State.

Maynard P. Pride M.D.

Maynard P. Pride, M. D., *President*

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EDITORIALS

THE NEW PRESIDENT

Dr. Maynard P. Pride, who has practiced his specialty of surgery in Morgantown since 1946, was installed as President of the West Virginia State Medical Association during the final session of the House of Delegates at The Greenbrier on August 23. He succeeds Dr. Richard W. Corbitt of Parkersburg, who will serve during the coming year as Chairman of the Council.

Doctor Pride is well qualified for this high office and has given freely of his time serving as a member of many key committees on both the local and state levels. He is one of few physicians who served for four terms as a member of the Council of the State Medical Association.

A native of Belpre, Ohio, Doctor Pride attended local public schools and was graduated from Marietta College in 1935. He received his M. D. degree in 1939 from Western Reserve University Medical School and served an internship at University Hospital in Cleveland, 1939-41. He also served a surgical residency at the Hospital prior to locating his practice in Morgantown.

He has been associated with the West Virginia University School of Medicine for a number of years and currently serves as Associate Clinical Professor of Surgery. He was certified by the American Board of Surgery in 1955 and he also is a member of the Southeastern Surgical Congress and the Southern Medical Association.

In 1966 he was appointed as a member of the Medical Licensing Board by former Gov. Hulett C. Smith.

He is active in civic affairs in Morgantown and has served as a member of the Board of Trustees of the Morgantown Chamber of Com-

Maynard P. Pride, M. D.

merce. He is a member of the Wesley Methodist Church in that community.

Dr. Pride served as a member of the Council of the State Medical Association from 1954 to 1958 and again during the period of 1963 to 1967. He was named Vice President of the Association in 1967 and President Elect the following year.

He is married to the former Sue Randall and is the father of five children.

The installation of Doctor Pride brought to an end a busy year for the retiring President, Dr. Richard W. Corbitt. Doctor Corbitt made an effort to visit every county society and also spent a great deal of time out of the State attending important regional and national meetings.

One of his greatest interests centered about the creation of a closer working relationship between members of the Association and students enrolled in the West Virginia University School of Medicine. This we believe he accomplished and certainly Doctor Pride and future presidents will see to it that this policy is continued.

Last, but not least, was the gracious manner in which Doctor Corbitt and Mrs. Corbitt served as host and hostess in the Association's hospitality suites during AMA conventions in Miami Beach and New York City. Also, nobody worked harder in the successful campaign to elect Dr. Carl Hoffman to the AMA Board of Trustees. Doctor Corbitt deserves a pat on the back for a job well done.

Heavy rain and generally bad weather failed to dampen the enthusiasm of the physicians, wives and guests in attendance at the 102nd Annual Meeting in August. A slight dip in attendance must be attributed to Hurricane Camille which affected parts of West Virginia during the early part of the week. Associated storms flooded highways in many areas of the State.

Ground fog also proved to be a nuisance. Governor Moore, who was scheduled to be the first speaker on Thursday morning, spent a couple of hours circling The Greenbrier in a plane before he could land and appear on the program later in the morning. The Program Committee deserves praise for hastily rearranging the schedule which gave the other speakers ample time to present their papers.

West Virginia physicians and their wives always have been known for their courteous treatment offered to honor guests at The Greenbrier. This year was no exception judging by the sentiments expressed in thank you notes received by the officers and the headquarters staff. Some excerpts from these letters follow:

"I would like to take this opportunity to tell you how great it was to have the opportunity to speak in front of the West Virginia State Medical Association. I was very happy and pleased with the fine reception I received. I could not have asked for nicer people and better attendance. Indeed, everybody was most kind and helpful to me. I cannot help but say that West Virginia is a beautiful state, a delightful place to visit and without doubt its people are wonderful."

"I want very much to thank you for the very warm and friendly hospitality that you and the doctors of the West Virginia State Medical Association gave me during my recent visit with my wife to The Greenbrier. We had a very pleasant time indeed. I do hope that my contributions were useful enough to justify the trouble that you took on our behalf."

"I thoroughly enjoyed meeting with and talking to the West Virginia doctors, and renewing acquaintanceship with several of my long-time friends."

"My wife and I both enjoyed tremendously our entire stay at The Greenbrier and were impressed with all the doctors and wives we had an opportunity to meet. I thought this was an excellent meeting."

"It was indeed a pleasure to take part in the program at The Greenbrier. I am only sorry that I didn't have more time to spend with you and my other new and old friends in West Virginia. I thoroughly enjoyed and was particularly heartened to meet Dean Sleeth and the neurologists and neurosurgeons, and of course yourself and all those great physicians of West Virginia. It was particularly exciting to meet Dr. Harris who had only missed one meeting in the last 50 years. It is stuff like this of which American medicine is made!"

"Thank you very much for your kind letter of August 27, and I must say both my wife and I enjoyed your annual meeting at The Greenbrier. I found the professional contacts with the members of the Association most rewarding and enjoyed participating in the scientific program. My wife, daughter, and her friend enjoyed the peace and quietness of The Greenbrier. We all had a wonderful time and would appreciate if you would convey our thanks to the program committee for their invitation. Once again, thanking you for a very happy occasion.

OCTOBER

The poet who sang, "What is so rare as a day in June?" might have been answered, in part at least, by inquiring, "What is so rare as a day in October?" From the medical point of view, June is not entirely a satisfactory month, for it is well known that more people attempt suicide, and more people actually die by their own hand in the month of June than in any other time of the year. Despite this somber reminder, we will grant that both June and October are wonderful months; we will not compare the two, because as the Greeks stated many years ago, comparisons are odious.

We will not discuss the beauty of June, but do want to say something about October. In most sections of the United States, October is regarded as a beautiful time of the year. The early mornings may be slightly foggy, and the mid-day may have a slight haze, presumably presaging Indian Summer, but all in all, the days are delightful and the sunsets gorgeous. We cannot subscribe to the sentiments expressed by the late Sir Arthur Conan Doyle when he writes in his novel, *The Hound of the Baskervilles*, ". . . but to me a tinge of melancholy lay upon the country-side, which bore so clearly the mark of the waning year." I like better the inimitable Boswell when he pens, ". . . in a serene autumn night."

To some people the fall of the year (autumn) is a rather depressing time, but to many, October is a satisfactory and restful time of the year. The crops have been garnered and housed, the blistering sun which shone so fiercely in July, is distinctly subdued, the sultry "dog-days" of August have safely passed, and Nature appears to be resting serenely from the tremendous labors of spring and summer.

AMA MEETING IN DENVER

The Mile-High City. The Queen City of the Plains. That's Denver—site of the 23rd Clinical Convention of the American Medical Association. Colorado's capital gains its nicknames, of course, from its altitude above sea level and its position at the western edge of the Great Plains near the foothills of the Rockies.

This Clinical Convention, scheduled for November 30 through December 3, is the third to be held in Denver. The most recent was in 1961. The first was in 1952.

Denver is unique in many ways. Its parks system includes 13,448 acres outside the city limits in the surrounding mountain area. (There also are numerous parks within the city and 26 miles of parkways). Even in late November and early December, the temperature can climb into the 60s (But it also can be breezy, and snow sometimes makes a brief appearance, so it's well to bring a varied wardrobe).

Headquarters hotel for the 23rd Clinical Convention is the Denver Hilton, towering over the downtown area and overlooking the State Capitol. (The 13th step on the West side of the Capitol is marked by a plaque exactly 5,280 feet above sea level).

Scientific sessions will be in Denver's convention complex. There are 165,000 square feet of exhibit space, seating for 24,000 and 22,055 square feet of new meeting rooms completed in 1966.

Denver has a population of a half-million, and there are more than a million people in the metropolitan area which includes Denver, Jeferson, Arapahoe, Adams and Boulder counties.

When snow falls, roads are cleared and sanded promptly, so travel in and around Denver remains uncomplicated for those wishing to explore the sights and activities of this dramatic locale.

The mountains, of course, are a major attraction. Colorado is the highest state in the Union with an average elevation of 6,800 feet. It has 53 peaks above 14,000 feet.

Denver itself has a number of professional and collegiate athletic teams, art and natural history museums, legitimate theater, a symphony orchestra, and a variety of restaurants and night clubs.

Golf and tennis are year-around sports in the Denver area, even in winter when skiers are gliding over Colorado's powder snow only 60 miles away. The front range of the Colorado Rockies is a half-hour drive from downtown Denver, and possible trips include Pike's Peak, the Central City gold mining area, Estes Park, Air Force Academy, Rocky Mountain National Park, and other Colorado cities.

Thus, the Denver area offers the physician and his family a refreshing change. And the professional program planned for AMA's 23rd Clinical Convention offers the physician the very latest in a variety of areas vital to his practice.

A constant flow of new prescription drugs from competing manufacturers results in rapid obsolescence of the industry's products. New products from different companies constantly move into the largest sales position. Example: None of the top five diuretic products of 1951, or their manufacturers ranked in that group by 1960.

GENERAL NEWS

Dr. Maynard P. Pride Heads State Association

Dr. Maynard P. Pride of Morgantown was installed as President of the West Virginia State Medical Association on the final day of the 102nd Annual Meeting at The Greenbrier, August 21-23.

Dr. Richard W. Corbitt of Parkersburg (left), retiring President of the Association, administers the oath of office to his successor, Dr. Maynard P. Pride of Morgantown.

The oath was administered to Doctor Pride by Dr. Richard W. Corbitt of Parkersburg, retiring President of the Association who will serve as Chairman of the Council for the next year.

The installation took place during the second and final session of the policy-making House of Delegates. Other features of the final session were the presidential address of Doctor Corbitt and the election of other officers to head the Association for the coming year.

Doctor Callender President Elect

Dr. George R. Callender, Jr., of Charleston, was elevated from Vice President to the office of President Elect. He will succeed Doctor Pride during the 103rd Annual Meeting next summer. Dr. Harry S. Weeks, Jr., of Wheeling was elected Vice President of the Association, and Dr. Kenneth G. MacDonald of Charleston, was named to his fifth consecutive term as Treasurer.

Election of Councilors

Three members of the Council were re-elected for two-year terms; one member who was serving out an unexpired term was elected to a term in his own right; and three physicians were elected to their first terms on the Council.

Re-elected were Drs. George A. Curry of Morgantown, Robert W. Bess, Jr., of Piedmont, and Dr. A. Thomas McCoy of Charleston. Dr. John J. Mahood of Bluefield, who was appointed during the year to fill the vacancy created by the resignation of Dr. W. H. St. Clair, Jr., was elected to his first full two-year term.

New members of the Council are Dr. Stephen D. Ward of Wheeling, who succeeded Doctor Weeks; and Drs. Joseph B. Reed of Buckhannon and J. D. H. Wilson of Clarksburg. Doctors Reed and Wilson succeeded Drs. R. L. Chamberlain of Buckhannon and Andrew J. Weaver of Clarksburg, neither of whom was eligible for re-election.

Holdover Councilors are Drs. William T. Lawson of Fairmont, S. Elizabeth McFetridge of Shepherdstown, A. Kyle Bush of Philippi, William E. Gilmore of Parkersburg, William L. Neal of Huntington, Joseph A. Smith of Dunbar and Harold Van Hoose of Man. Dr. Richard V. Lynch, Jr., of Morgantown, Chairman of the Council for the past year, becomes Councilor at Large.

Doctor Flood Elected AMA Delegate

Dr. C. A. Hoffman of Huntington, who was elected to the Board of Trustees of the American Medical Association in July, announced his resignation as an AMA Delegate during the Second Session of the House, and Dr. Richard E. Flood of Weirton, who has been serving as Alternate Delegate, was elected Delegate for the remaining year in Doctor Hoffman's two-year term. Dr. Albert C. Esposito of Huntington was elected Alternate Delegate for one year to succeed Doctor Flood.

Drs. Frank J. Holroyd of Princeton and Thomas G. Reed of Charleston were re-elected AMA Delegate and Alternate Delegate, respectively, for two-year terms.

Doctor Pride Ohio Native

Doctor Pride, the new President, was born in Belpre, Ohio, in 1914. He attended elementary and secondary schools there before enrolling in Marietta College,

where he received a degree in 1935. He attended the Western Reserve University Medical School in Cleveland, where he received the M. D. degree in 1939.

He served his internship and a surgical residency at University Hospital in Cleveland and entered the private practice of surgery in Morgantown in 1946. He serves as Clinical Associate Professor of Surgery at the West Virginia University School of Medicine.

A Diplomate of the American Board of Surgery, Doctor Pride is a member of the Southern Medical Association and the Southeastern Surgical Congress in addition to the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He is a member of the West Virginia Medical Licensing Board.

Married to the former Sue Randall, Doctor Pride is the father of five children.

The President Elect

Doctor Callender, the new President Elect, is engaged in the practice of orthopedic surgery in Charleston. He was born in Washington, D. C., and received his M. D. degree in 1945 from the University of Maryland School of Medicine.

For several years Doctor Callender chaired the Association's Medical Economics Committee. He was elected to the Council in 1966 and was named Vice President at the Annual Meeting of 1968. He is a Past President of the Kanawha Medical Society.

The Vice President

Doctor Weeks, who was named Vice President, is an anesthesiologist in Wheeling. He was born in Clarksburg and received his M. D. degree from the University of Maryland School of Medicine in 1953. Like Doctor Callender, Doctor Weeks has served as Chairman of the Association's Medical Economics Committee.

Doctor Weeks was elected to the Council in 1967.

This is one of the many, many small conversation groups which could be seen in the Exhibit Center at recess during the Annual Meeting. Pictured (left to right) are: Dr. S. William Goff of Parkersburg; Dr. Jack J. Stark of Parkersburg, who served as Program Chairman for this year's meeting; and Dr. Maynard P. Pride of Morgantown, the incoming President.

Amendments to By-Laws

The House adopted three proposed amendments to the By-Laws of the Association. One amendment in effect allows recipients of the Association's four-year scholarships at the West Virginia University School of Medicine to fulfill their obligations by practicing

Gov. Arch A. Moore, Jr., was one of the honor guests at the Annual Meeting. He is shown here (second from left) chatting with some old friends prior to delivering his address. Talking with the Governor are: Dr. Harry S. Weeks, Jr., of Wheeling (left); Dr. Stephen D. Ward of Wheeling; Dr. Frank J. Holroyd of Princeton; and Dr. Richard E. Flood of Weirton.

Physicians from 19 States Attend Annual Meeting

Physicians from 19 states and the District of Columbia were in attendance at the 102nd Annual Meeting at The Greenbrier in August. Registration cards revealed that physicians traveled to White Sulphur Springs from as far as California, Massachusetts and Texas. Physicians also were registered from the following states:

Alabama, Florida, Kansas, Indiana, Kentucky, Maryland, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Virginia and Wisconsin.

anywhere in the State rather than in an area classified as rural.

Another amendment prescribes selection of the Nominating Committee for each Annual Meeting, and the third amendment removes from the By-Laws a prohibition against campaigning for Association offices.

Honor Guests

Two honor guests presented addresses during the 102nd Annual Meeting, and their texts will be published in the November issue of *The Journal*. Dr. Gerald Dorman of New York City, President of the American Medical Association, spoke at the first session of the House of Delegates, and Gov. Arch A. Moore, Jr., was a speaker at the first general scientific session.

Presidential Address

Doctor Corbitt, the retiring President, presented his Presidential Address at the final session of the House. His remarks are published elsewhere in this issue of *The Journal*.

Doctor Sleeth Receives Checks

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, attended the final session of the House to accept for the School two checks. One check in amount of $12,778.49 represented the year's contributions of West Virginia physicians and Auxiliary members to the School of Medicine through the American Medical Association's Education and Research Foundation. Another check in the amount of $5,000 was authorized by the Association's Committee on Medical Scholarships for student loans.

103rd Meeting at The Greenbrier

The Council voted to conduct the 103rd Annual Meeting at The Greenbrier on Thursday, Friday and Saturday, August 20-22, 1970.

Flash-flooding during convention week in the Greenbrier County area was blamed for a slight decrease in attendance compared with registration in recent years. Total registration was 642, compared with 658 in 1968. The physician registration was 368, compared with 384 last year. The Auxiliary registration was 175, compared with 185 in 1968, and total registration of exhibitors and other guests was 99.

MLB Licenses 23 Physicians To Practice in State

The Medical Licensing Board of West Virginia licensed 23 physicians to practice medicine in the State of West Virginia by direct examination at a meeting held at The Capitol in Charleston, June 18-20, 1969:

Barrett, Edgar Leicester, Wheeling
Bernam, Anis Matta, Beckley
Carter, Thomas Edward, New Rochelle, N. Y.
Cavendish, John Watson, II, Rainelle
Celis, Jose Arcinas, Charleston

Ferrell, Robert Lee, Omaha, Nebraska
Friedlander, Barry Robert, Baltimore, Md.
Gomez, Aurelio Rafael, Charleston
Hughes, Charles Vincent, Wauwatosa, Wisc.
Joseph, Robert Lance, Harrisburg, Pa.
Kivlahan, Francis Matthew, Wheeling

Majzoub, Hisham Salem, Morgantown
McMillan, Gary Lee, Vienna
Molina, Rafael Evencio, Huntington
Nichols, Carl Edwin, Morgantown
Orteza, Arsenio Miranda, Morgantown
Porter, Charles Vernon, Moundsville

Sakhai, Hossein, Huntington
Saliga, Suzanne Bernadette, Morgantown
Shepherd, James Banks, Jr., Charleston
Steahley, Lance Preston, Silver Spring, Md.
Vernocy, William Gary, Indiana, Pa.
Walker, Jon Gilchrist, Pittsburgh, Pa.

The next meeting of the MLB will be held at The Capitol in Charleston on October 6, 1969, for the purpose of licensing physicians by reciprocity to practice medicine in the State of West Virginia.

Three State Medical Chiefs Attend Annual Meeting

The Presidents of three sister state medical associations were guests at the 102nd Annual Meeting of the West Virginia State Medical Association at The Greenbrier, August 21-23.

They are Drs. Robert N. Smith of Toledo, Ohio, President of the Ohio State Medical Association; Henry B. Asman of Louisville, President of the Kentucky Medical Association; and G. E. Farrar, Jr., of Philadelphia, President of the Pennsylvania Medical Society.

Dr. Russell S. Fisher of Baltimore, President of the Medical and Chirurgical Faculty of Maryland, could not be present, but he was represented by Dr. Archie R. Cohen of Clear Spring, Maryland.

1970 Meeting at The Greenbrier

At its pre-convention meeting, the Council voted to hold the 103rd Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs. The meeting is scheduled for August 20-22, 1970.

Cleveland Clinic Foundation Lists PG Courses

The Cleveland Clinic Educational Foundation has announced its 1969-70 schedule of postgraduate courses in medical education. They are as follows:

October 3—"Medical Technology."

November 6-7—"Perspectives in Lipids and Lipoproteins (Newer Methods and Applications)."

November 12-13—"Diseases of the Small Intestine and Colon."

November 19-20—"Neurosurgical Technics."

December 3-4 — "Respiratory Failure — Acute and Long-Term Management."

December 10-11—"Concepts in Diagnosis and Management of Diseases of Vitreous, Retina and Choroid."

January 14-15—"Selected Problems in General Surgery and Vascular Surgery."

February 4-5—"General Practice."

February 25-26—"Selected Topics in Basic and Clinical Immunology."

March 11-12—"Current Management of Common Orthopaedic Problems."

March 25-26—"Medical Progress and Its Relationship to Dentistry."

April 1-2—"Advances in Infectious Disease."

April 6-7—"Sports Medicine."

April 22-23—"Postgraduate Course in Pathology."

May 6-7—"Progress in Cardiovascular Disease."

May 21-22—"Advances in Dermatology."

Additional information about these courses may be obtained by writing to: Director of Education, the Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Narcotics Office in Charleston

The Federal Bureau of Narcotics and Dangerous Drugs will open an office in Charleston during the next few months, according to Rep. John Slack.

He said there have been reports of illicit drug distribution in his district and that the field office will allow the Bureau to "extend its close surveillance to Southern West Virginia until this very serious threat to our young people can be wiped out."

1970 Program Committee

Dr. Robert J. Fleming of Morgantown will serve as Chairman of the Program Committee for the 103rd Annual Meeting of the West Virginia State Medical Association next year.

The appointment of Doctor Fleming was announced by the Association's new President, Dr. Maynard P. Pride of Morgantown.

Other physicians named to the Program Committee by Doctor Pride are Dr. Charles E. Andrews of Morgantown, Dr. A. Thomas McCoy of Charleston, and Dr. Thomas Long of Man.

Two state officials were speakers at the Pre-Convention meeting of the Council at The Greenbrier. They are Mr. Fred Davis (left), Workmen's Compensation Commissioner; and Mr. Edwin Flowers, State Welfare Commissioner. Between them is Dr. Richard V. Lynch, Jr., of Morgantown, Chairman of the Council.

Scientific Sections & Societies Elect New Officers

Several scientific sections and societies affiliated with the West Virginia State Medical Association elected new officers for the coming year during the 102nd Annual Meeting at The Greenbrier. They are as follows:

West Virginia State Society of Allergy—Dr. Martin D. Reiter of Wheeling, President; and Dr. Merle S. Scherr of Charleston, Secretary-Treasurer.

West Virginia Radiological Society—Dr. Donald R. Bernhardt of Parkersburg, President; Dr. Berthold H. Goerlich of Elkins, Vice President; and Dr. J. Dennis Kugel of Charleston, Secretary-Treasurer.

West Virginia Obstetrical and Gynecological Society —Dr. Robert Greco of Morgantown, President; Dr. Warren D. Elliott of Beckley, Vice President; and Dr. A. J. Villani of Welch, Secretary-Treasurer.

Section on Orthopedic Surgery—Dr. William R. Barton of Wheeling, President; Dr. Nicholas Zambos of Beckley, Vice President; and Dr. James H. Wiley of Morgantown, Secretary-Treasurer.

Section on Surgery—Dr. S. William Goff of Parkersburg, Chairman.

Section on Neurology, Neurosurgery and Psychiatry —Dr. Robert W. Hibbard of Huntington, President; Dr. Thomas S. Knapp of Charleston, President Elect; and Dr. Florence K. Hoback of Huntington, Secretary.

Section on Internal Medicine—Dr. James T. Hughes of Ripley, President.

Section on Urology—Dr. Harold N. Kagan of Huntington, President; and Dr. A. Thomas McCoy of Charleston, Secretary-Treasurer.

Regional ACP Meeting in Baltimore

A regional meeting of the American College of Physicians will be held in Baltimore, Maryland, on October 11, with Dr. Samuel P. Asper of Baltimore, President of the ACP, as special quest.

The session, one of 35 regional scientific-educational meetings the ACP will sponsor during the current academic year, is primarily for members of the College in Maryland and the District of Columbia.

Dr. A. B. Curry Ellison of Charleston (center) was Moderator for the Friday morning scientific program. With him are two of the guest speakers, Dr. Felix de la Cruz of Bethesda, Maryland (left), and Dr. Kermit E. Krantz of Kansas City, Kansas.

Dr. L. J. Pace of Princeton (center in front row) presided at a meeting of the Committee on Mental Health during the Annual Meeting. Also in front row are Drs. Mildred M. Bateman of Charleston, State Director of Mental Health, and S. Elizabeth McFetridge of Shepherdstown. Standing are Drs. Roy Edwards of Huntington and Harry S. Weeks, Jr., and Stephen D. Ward, both of Wheeling.

Action Taken on Amendments To Constitution and By-Laws

The House of Delegates of the West Virginia State Medical Association adopted several amendments to the By-Laws during the 1969 Annual Meeting at The Greenbrier.

The following three amendments to the By-Laws were adopted:

Amend Chapter VIII, Section 5, Sub-Section (k) by deleting the second sentence and substituting therefor the following: "It shall have sole authority in the placement of recipients of this program and shall be empowered to accept scholarship funds from any legitimate source."

(Note: Adoption of this amendment makes it possible for recipients of scholarships awarded by the State Medical Association to locate and practice anywhere in the State to fulfill their obligation to the Association. Previously, the contract stipulated that recipients must practice in rural areas approved by the Scholarship Committee).

Amend Chapter VIII, Section 5, Sub-Section (o) by deleting the first sentence and substituting therefor the following: "The Committee on Nominations shall consist of seven district councilors, and the Junior-Councilor-at-Large, who shall serve as Chairman. The

The Committee on Nominations met on Friday evening during the Annual Meeting. Front: Dr. Richard E. Flood of Weirton, Chairman; and Dr. A. Thomas McCoy of Charleston. Standing: Dr. George A. Curry of Morgantown and Dr. Harry S. Weeks, Jr., of Wheeling.

These physicians participated in the Saturday morning "Symposium on Cardio-Respiratory Emergencies and Their Management." Front: Dr. E. M. Papper of New York City and Dr. W. Glenn Young, Jr., of Durham, North Carolina. Standing: Dr. N. W. B. Craythorne of Morgantown, Moderator; and Dr. Bruce C. Sinclair-Smith of Nashville, Tennessee.

Councilors from the odd-numbered districts shall serve as the nominating committee in odd-numbered years, and the Councilors from even-numbered districts shall serve in even-numbered years. The Kanawha Medical Society shall select one of its two councilors to serve on the Committee."

Amend Chapter V, by deleting Section 2, which states, "any person known to have solicited votes for or sought any office within the gift of the Association shall be ineligible for election to any office for two years."

Proposed Constitutional Amendment

One proposed amendment to the Constitution was offered at the first session of the House of Delegates. The amendment will be submitted to the House of Delegates for final action at the 103rd Annual Meeting at The Greenbrier next August. The proposed amendment reads as follows:

Amend Article V, Section 1, by deleting Sub-Section (2) which reads as follows: "ex-presidents for a period of 10 years following their tenure of office, providing, however, that ex-presidents who were elected prior to 1953 shall remain as life-time members of the House of Delegates; and,"

If approved, past presidents of the Association would have to be elected as delegates by their component societies in order to have a vote at the meetings of the House.

These physicians were elected to offices at the final session of the House of Delegates during the Annual Meeting. Left to right: Dr. Albert C. Esposito of Huntington, Alternate AMA Delegate; Dr. Richard E. Flood of Weirton, AMA Delegate; Dr. Maynard P. Pride of Morgantown, who was installed as President; Dr. Kenneth G. MacDonald of Charleston, who was elected to his fifth term as Treasurer; Dr. Richard W. Corbitt of Parkersburg, who retired as President and became Chairman of the Council; Dr. Harry S. Weeks, Jr., of Wheeling, Vice President; and Dr. George R. Callender, Jr., of Charleston, President Elect.

These members were elected to terms on the Council of the Association. Left to right: Dr. John J. Mahood of Bluefield; Dr. Joseph B. Reed of Buckhannon; Dr. Richard W. Corbitt of Parkersburg, Immediate Past President who automatically serves as Council Chairman for one year; Dr. Stephen D. Ward of Wheeling; and Dr. George A. Curry of Morgantown.

These physicians and laymen participated in a Seminar on "Investments and Insurance for Physicians," which was a feature of this year's Annual Meeting. Seated: Mr. J. Banks Shepherd of Charleston, Administrator of the group insurance plan sponsored by the State Medical Association; Dr. C. A. Hoffman of Huntington, Moderator for the discussion; and Dr. Thomas Sexton of Springfield, Massachusetts. Standing: Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association; and Mr. E. H. Morgan of Hartford, Connecticut.

The Committee that will plan the program for the 1970 Annual Meeting next year found time for a brief conference during this year's convention. Seated (left to right) are: Dr. Maynard Pride of Morgantown, President of the Association who appointed the Committee; Dr. Robert J. Fleming of Morgantown, Chairman; and Dr. A. Thomas McCoy of Charleston. Standing: Dr. Thomas Long of Man and Dr. Charles E. Andrews of Morgantown.

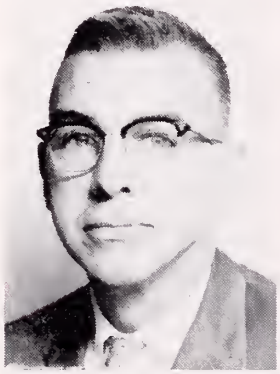
Maj. Gen. Joe M. Blumberg (second from left), one of the guest speakers, is shown talking with three members of the Association— Dr. Seigle W. Parks of Charleston (left); Dr. Jack J. Stark of Parkersburg, Chairman of the Program Committee; and Dr. Richard W. Corbitt of Parkersburg, President of the Association.

In one of the rare strictly candid shots the Official Association Photographer managed to get during the meeting, Drs. Rigoberto Ramirez of Buckhannon (left) and Forest A. Cornwell of Beckley (right) share a laugh with Dr. Kenneth G. MacDonald of Charleston.

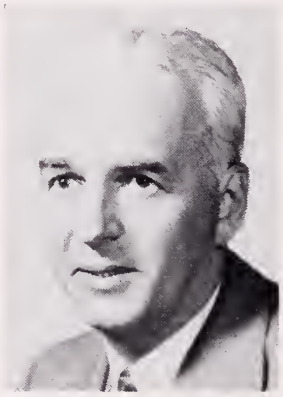
17th Annual Bluefield Seminar On October 16

The 17th Annual Seminar sponsored by the Bluefield Sanitarium Clinic and affiliated clinics will be held at the Bluefield Country Club on October 16.

Co-sponsors are the Stevens Clinic in Welch and the Clinch Valley Clinic in Richlands, Virginia.



Henry F. Warden, Jr., M. D.



Wm. B. Kieswetter, M. D.

There will be a scientific session beginning at 2:30 P. M., and a social hour and dinner afterward. Mr. J. P. Wilbern, Administrator of the President's Council on Physical Fitness annd Sports, will be the after-dinner speaker.

Mr. Wilbern's subject will be "The Mission of the President's Council on Physical Fitness and Sports."

Scientific speakers will include Dr. Hugh Davis of the Johns Hopkins Hospital, who will present a discussion of "Cervical Cancer Control with Cytologic Screening"; Dr. William B. Kieswetter of the University of Pittsburgh, who will discuss "Gastrointestinal Bleeding in Infancy and Childhood"; and Dr. Henry F. Warden, Jr., of the Bluefield Sanitarium Clinic, who will speak on "Pneumoconiosis Defined."

Dr. Frederick T. Edmunds of the Bluefield Sanitarium Clinic's Department of Obstetrics and Gynecology is in charge of program arrangements.

Hancock Society Entertains Medical Students

The Hancock County Medical Society has taken steps to establish a clear channel of communication with medical students from the Weirton area.

The Society held a dinner meeting in Steubenville, Ohio, recently and invited Hancock County Medical students to come. Both county society members and the students termed the meeting successful and another get-together is planned for December when the students are home for the Christmas holidays.

Dr. Ray S. Greco, President of the Society, announced creation of a Physician-Student Relations Committee, which will include Dr. Milan Packovich and Mr. Meredith C. Clubb, a medical student. They will plan future programs.

Telephone Q. & A. Service Started in Alabama

Physicians in Alabama now have up-to-date medical information as close at hand as the nearest telephone.

The unique MIST program, acronym for "Medical Information Service via Telephone" was inaugurated on July 1 by the Medical College of Alabama and the Alabama Regional Medical Program.

A special toll-free telephone number may be used by any doctor in Alabama to receive information needed for patient care. The service is available 24 hours a day, seven days a week.

"It brings a medical service right into the physician's office," said Dr. Thomas W. Sheehy, Professoı of Medicine at the Medical College. "Nowhere else can a doctor call a medical center free of charge and receive personal answers to his questions from some of the most highly qualified specialists in the nation."

All telephone conversations are tape-recorded, and physicians receive immediate attention to their questions.

A preliminary survey indicated that about one-fourth of the calls were related to the treatment of cancer and about one-fourth to the diagnosis and treatment of heart disease and stroke.

Mrs. Martha Hooks of Birmingham, Alabama, was on hand at the Annual Meeting to inform members of the advantages of also joining the Southern Medical Association. At left is Dr. Albert C. Esposito of Huntington, who has been an active member and officer of SMA. At right is Dr. Worthy McKinney of Beckley, a member of the Council of the State Association. The three doctors in the right photo are awaiting the opening of the second session of the House of Delegates. They are (left to right) Dr. Vernon L. Dyer of Petersburg; Dr. Samuel J. Bucher of Harman; and Dr. E. E. Hutton, Jr., of Elkins.

Annual McGuire Lecture Series In Richmond, Oct. 23-24

The 41st Annual McGuire Lecture Series will be held at the Medical College of Virginia in Richmond, October 23-24.

Subject matter at the two-day meeting will center around dermatology and "Advances in Pathophysiology and Therapy of Skin Disease."

The McGuire Lecture will be presented by Dr. Eugene Van Scott, Professor of Dermatology, Skin and Cancer Hospital, Temple University Health Sciences Center, Philadelphia. His subject will be "Development and Evaluation of Topical Agents in the Management of Psoriasis."

AAMC Lists Annual Meetings

"The Health Care Dilemma—New Directions for Medical Education!" is the theme for the 80th Annual Meeting of the Association of American Medical Colleges, which will be held in Cincinnati, Ohio, October 31 through November 3.

Dr. John A. D. Cooper, who was installed earlier this year as the first permanent President of the Association, will preside at the sessions.

More than 1,500 leading medical academicians from universities and hospitals in the United States, Canada and Europe are expected to attend the four-day meeting.

Dr. Albert C. Esposito To Lecture Abroad

Dr. Albert C. Esposito of Huntington will be among scientific speakers at the Annual Meeting of the American Diopter and Decibel Society, which will be held in Curcao, West Indies, next March 8-15.

Doctor Esposito will present two papers, one on "A New Look at Ocular Surgery" and the other on "Ocular Anesthesia." He also will be a speaker at the General Eye Session at the Aruba General Hospital in Aruba, West Indies.

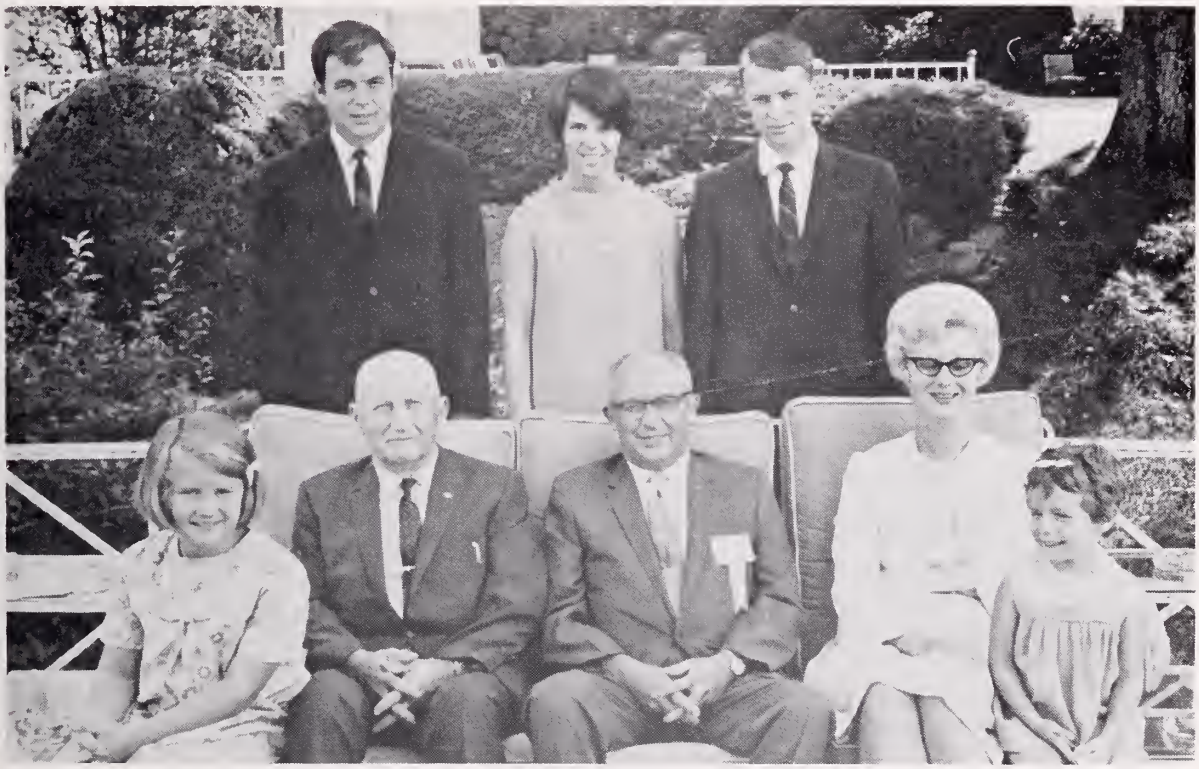
The Huntington ophthalmologist is a Past President of the West Virginia State Medical Association and the West Virginia Academy of Ophthalmology and Otolaryngology.

Additional information about the meeting of the Diopter and Decibel Society may be obtained by writing to the Secretary, Dr. E. A. Rittenhouse, 203 Masonic Building, McKeesport, Pennsylvania.

New AMA Staff Officer

Mr. Kenneth T. Simendinger, a former Washington, D. C., public relations man, has been named Director of Media Relations for the American Medical Association in Chicago.

In his new position, Mr. Simendinger will direct the departments of press relations, radio and television and motion pictures, magazine relations, women's activities, and youth programs.



Most members of the family of Dr. Maynard P. Pride had the pleasure of witnessing his installation as President of the West Virginia State Medical Association during the 102nd Annual Meeting. Doctor Pride and his family took a brief time out from the convention activities to pose for this picture. In the front row are: daughter Amy, 10; Mr. Eber P. Pride of Belpre, Ohio, the new President's father; Doctor Pride; Mrs. Pride; and daughter Heidi, 4. Back row: son Robert Pride; a daughter, Mrs. Janet Pride Anderson; and Mrs. Anderson's husband, Keith Anderson. Unable to attend the meeting was another son, John B. Pride of Charlotte, North Carolina.

Pre-Convention Council Meeting At The Greenbrier, Aug. 20

The Pre-Convention Meeting of the Council was held at The Greenbrier in White Sulphur Springs on Wednesday, August 20, with the Chairman, Dr. Richard V. Lynch, Jr., of Morgantown, presiding.

At the outset, Doctor Lynch announced that Dr. James S. Klumpp, the Parliamentarian, had notified him he would be unable to attend the meeting due to the illness of his wife. The Executive Secretary was instructed to send a telegram on behalf of the members of the Council extending best wishes to both Doctor and Mrs. Klumpp.

Appearance of State Officials

Present at the meeting were the Hon. Fred L. Davis, Jr., Commissioner of the State Workmen's Compensation Fund, and the Hon. Edwin F. Flowers, Commissioner of the Department of Welfare. Also in attendance was Dr. J. L. Mangus, Medical Director of the Welfare Department.

Mr. Davis discussed changes in the Compensation program which have been made since he was appointed Commissioner by Gov. Arch A. Moore, Jr. He also outlined plans for additional changes under consideration.

He complimented the members of the Association's Sub-Committee on Workmen's Compensation, with whom he had met on several occasions during the past few months. As a result of these meetings, he said, a cordial relationship had been developed between the State Medical Association and the Fund.

Mr. Davis reported that a new set of rules and regulations was in the process of being promulgated and he expected it would be completed during the next few months. He also said he hoped it would be possible for the Fund to employ a physician to serve as part-time medical director.

Mr. Flowers explained in detail changes which have been made in the administration of the Welfare program since he assumed office. He said the most important change to date was the elimination of district and county offices and establishment of area offices throughout the State.

He said this change was recommended by the Task Force named by Governor Moore and it was estimated this was one manner in which the Department might expect to save $2.5 million annually.

Mr. Flowers praised the work of Doctor Mangus and Dr. Harry S. Weeks, Jr., Chairman of the Joint Conference Committee, which meets periodically with the Welfare Commissioner.

He reported that 1,227 West Virginia physicians were currently rendering services to Welfare recipients. He said the Department processed a total of 24,333 invoices during the month of July.

Mr. Flowers also outlined in detail proposed changes in the program which would affect both recipients and those providing the services.

1970 Meeting at The Greenbrier

It was reported that the management at The Greenbrier was holding the dates, August 20-22, 1970, for the 103rd Annual Meeting of the State Medical Association.

The Council went on record unanimously as approving The Greenbrier as the place for the 1970 meeting during the above mentioned dates.

Retiring Councilors

Doctor Corbitt pointed out that two physicians had completed two consecutive terms of service as members of the the Council and therefore would not be eligible for election: Drs. Andrew J. Weaver of Clarksburg and Robert L. Chamberlain of Buckhannon.

The Council went on record unanimously as expressing sincere thanks and appreciation to Dr. Richard V.

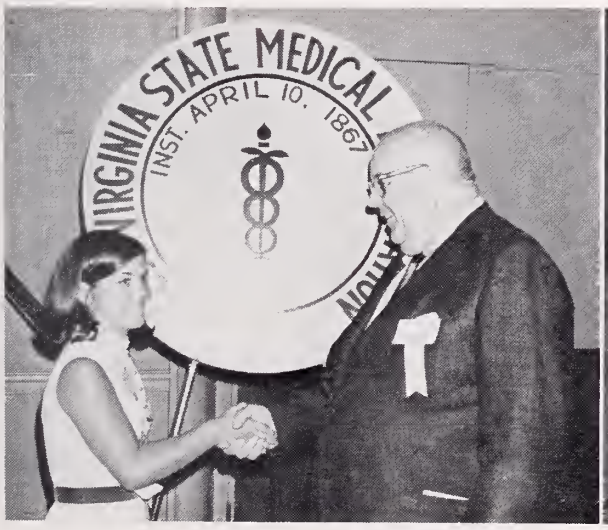
The Section on Surgery had two speakers at its meeting (left photo). Drs. W. Glenn Young, Jr., of Durham, North Carolina (left) and Raymond J. Jackman of Rochester, Minnesota (center), also presented papers at the general scientific sessions. With them is Dr. Alvin L. Watne of Morgantown, Chairman of the Section on Surgery. Dr. C. Douglas Maynard of Winston-Salem, North Carolina, (center in right photo), was the guest speaker at a meeting of the West Virginia Radiological Society. At left is Dr. W. Alva Deardorff of Charleston, and at right is Dr. Andrew W. Goodwin II, also of Charleston, President of the Society.

In left photo, Dr. George R. Callender, Jr., the new President Elect, greets Mr. C. Judson Pearson of Charleston during the reception honoring new officers of the Association as Mrs. Richard W. Corbitt of Parkersburg, wife of the retiring President, looks on. In right photo, Dr. Edward R. Annis of Miami, Florida (right), congratulates the newly-installed President, Dr. Maynard P. Pride of Morgantown. In center of picture is Mrs. Pride.

Lynch, Jr., for his dedicated service as Chairman of the Council during the past year.

The Council meeting was attended by Dr. Richard V. Lynch, Jr., of Morgantown, Chairman; Dr. Richard W. Corbitt of Parkersburg, President; Dr. Maynard P. Pride of Morgantown, President Elect; Dr. George R. Callender, Jr., of Charleston, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Richard E. Flood of Weirton, Councilor at Large; Dr. Seigle W. Parks of Charleston, Past President; Drs. Harry S. Weeks, Jr., of Wheeling; William T. Lawson of Fairmont; George A. Curry of Morgantown; S. Elizabeth McFetridge of Shepherdstown; A. Kyle Bush of Philippi; R. L. Chamberlain of Buckhannon; William E. Gilmore of Parkersburg; William L. Neal of Huntington; Joseph A. Smith of Dunbar; A. Thomas McCoy of Charleston; Worthy W. McKinney of Beckley; Harold Van Hoose of Man; and John J. Mahood of Bluefield; and Mr. William H. Lively of Charleston, Secretary ex officio; and Mr. Edward D. Hagan of Charleston, Executive Assistant.

The meeting also was attended by: Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. N. H. Dyer of Charleston, State Health Director; Drs. A. C. Esposito of Huntington, D. E. Greeneltch of Wheeling and L. J. Pace of Princeton, Past Presidents of the State Medical Association; Dr. Stephen D. Ward of Wheeling; Dr. J. L. Mangus of Charleston, Medical Director, State Welfare Department; Mr. Edwin F. Flowers, Commissioner of the Department of Welfare; and Mr. Fred L. Davis, Jr., Commissioner of the State Workmen's Compensation Fund.



In left photo, two old friends, Miss Mary Louise Corbitt of Parkersburg, and Dr. Richard E. Flood of Weirton, a Past President of the Association, shake hands at the conclusion of the Annual Meeting. Mary Louise is the youngest of five daughters of Dr. Richard W. Corbitt, retiring President of the Association. At right, Dr. Richard V. Lynch, Jr., of Morgantown, another Past President, talks with Dr. Henry B. Asman of Louisville, Kentucky, President of the Kentucky Medical Association.

Potomac-Shenandoah Institute Program Is Announced

The 15th Annual Potomac-Shenandoah Valley Postgraduate Institute, one of West Virginia's most widely known medical meetings, will be held in Martinsburg on Friday, Saturday and Sunday, October 31 through November 2.

D. Frank Kaltreider, M. D.

Walter A. Bonney, M. D.

Many outstanding clinicians and laymen have accepted invitations to speak during the three-day meeting, which is expected to attract about 200 persons, according to Dr. Halvard Wanger of Shepherdstown, Executive Director of the Institute.

The meeting is co-sponsored by the Institute and the West Virginia Chapter of the American Academy of General Practice. Application has been made to the AAGP for 18 hours of credit for members who attend the lectures.

Headquarters for the meeting will be the Gateway Inn, formerly known as the Shenandoah Hotel, and scientific sessions will be held in the Apollo Theater, about a block away.

There will be a panel discussion following each morning and afternoon session, and at noon on Friday and Saturday, there will be round table luncheons with a visiting speaker leading discussions at the individual tables.

The program had not been completed as this issue of *The Journal* went to press, but Doctor Wanger said the following events, speakers and titles would be included:

Friday Morning Program

The Friday morning scientific program will be devoted to basic science and will include the following:

"Surgical Diagnostic Problems"—Manuel E. Lichtenstein, M. D., Professor of Surgery, Cook County Graduate School of Medicine, and Associate Professor of Surgery Emeritus, Northwestern University School of Medicine.

Hugh A. Lindsay, Ph. D., Associate Professor of Physiology, WVU Medical Center (subject to be announced).

Friday Afternoon Program

Lectures in obstetrics and gynecology will dominate the Friday afternoon portion of the program. Speakers and subjects are as follows:

"Psychological Sequelae of Sterilization"—D. Frank Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland School of Medicine.

"Office Obstetrics and Gynecology"—James G. Sites, M. D., Professor of Obstetrics and Gynecology, George Washington University School of Medicine.

"The Evaluation and Treatment of Ovarian Masses"—Walter A. Bonney, Jr., M. D., Professor and Chairman, Department of Obstetrics and Gynecology, WVU Medical Center.

Friday Night Dinner

The annual Friday evening dinner will be held beginning at 5:30 P. M. The speaker will be Maurice Brooks, Professor of Wildlife Management and Forestry at West Virginia University, and his topic will be "The Appalachians."

Saturday Morning Program

The Saturday morning program will consist of lectures in the basic sciences and pediatrics as follows:

"Factors Influencing the Growth of the Prostate Gland"—John A. Thomas, Associate Professor of Pharmacology, WVU Medical Center.

"Applied Anatomy of the Portal Vein"—Robert J. Johnson, M. D., Chairman of the Department of Anatomy, University of Pennsylvania Graduate School of Medicine.

"Hypertension in Pediatrics"—Charles Hollerman, M. D., Associate Professor of Pediatrics, Georgetown University School of Medicine.

"Respiratory Distress in the Newborn"—Joseph LoPresti, M. D., Clinical Associate Professor of Radiology, Children's Hospital, Washington, D. C.

"Hypoglycemia in Children"—Malcolm M. Martin, Professor of Pediatrics, Georgetown University School of Medicine.

"Convulsive Disorders of Childhood"—Alexander V. Fakadej, M. D., Instructor in Pediatric Neurology, WVU Medical Center.

Saturday Afternoon Program

Saturday afternoon speakers and topics will include the following:

"The Paranoid Wife Syndrome"—Donald C. Carter, M. D., Associate Professor of Psychiatry, WVU Medical Center.

"Current Concepts and Management of Leukemia"—Charles W. Stuart, M. D., Associate Professor of Medicine, Johns Hopkins University School of Medicine.

"Newer Problems in Neurology"—Thomas L. Auth, M. D., Associate Professor of Neurology, Georgetown, University School of Medicine.

Annual Banquet

The Annual Banquet will be held Saturday evening.

The after-dinner speaker will be the Rev. Francis Joseph Heyden, S. J., Ph. D., Professor and Chairman of the Department of Astronomy at Georgetown University. He will speak on "Life on Other Planets."

Sunday Morning Program

The final scientific session will be held on Sunday and speakers will be as follows:

"Mechanism of Action of Cardiovascular Drugs"—John L. Egle, Ph. D., Associate Professor of Pharmacology, Medical College of Virginia.

"Functional Anatomy of the Nephron"—Robert J. Johnson, M. D., Chairman of the Department of

Robert J. Johnson, M. D.

M. E. Lichtenstein, M. D.

Anatomy, University of Pennsylvania Graduate School of Medicine.

"Uses and Abuses of Topical Therapy"—Raymond C. V. Robinson, M. D., Associate Professor of Dermatology, University of Maryland School of Medicine.

"Thyrotoxicosis—Advances in Treatment"—W. Lester Henry, M. D., Professor and Chairman of the Department of Medicine, Howard University School of Medicine.

"Diabetic Ketoacidosis"—James M. Moss, M. D., Associate Professor of Medicine, Georgetown University School of Medicine.

Fees and Information

The registration fee is $25 per person for the entire three-day meeting, and $10 for a single day. Additional information about the meeting may be obtained by writing to Dr. Halvard Wanger, Executive Director, Potomac-Shenandoah Valley Postgraduate Institute, P. O. Box 175, Shepherdstown, West Virginia 25443.

Family Planning Clinic Sought For Every County

In his address to Congress on July 18, 1969, President Nixon had this to say concerning family planning:

"In 1830, there were 1 billion people on the planet earth. By 1930, there were 2 billion, and by 1960 there were 3 billion. Today, the world population is 3.5 billion and by the year 2000, it is expected to reach 7 billion.

"In the United States, our rate of population growth is not as great as that of developing nations in Latin America, Asia and Africa; however, the present growth rate of one per cent per year is still significant.

"In 1917 the total number of Americans passed 100 million, after three full centuries of steady growth. In 1967—just half a century later, the 200 million mark was passed. If the present rate of growth continues, the third 100 million will be added in roughly a 30-year period. This means that by the year 2000, or shortly thereafter, there will be more than 300 million Americans."

These awesome figures certainly should produce some serious thoughts on the world's population explosion and what can and should be done about it. At this rate of growth it will soon be impossible to feed, house, clothe, educate or give proper health care to all of these people. This is one of the major reasons that the federal and state governments are placing so much emphasis and investing so much money on family planning and child spacing projects in this country and throughout the world.

According to the West Virginia Department of Health, these are just a few of the objectives for a good family planning program:

1. Assist parents in attaining and maintaining the family size they desire.
2. Assist families in spacing their children.
3. Decrease infant and maternal mortality and morbidity by allowing sufficient time between pregnancies for the mother to regain her strength so that the outcome of pregnancy will be better.
4. Decrease out-of-wedlock births.
5. Decrease the incidence of prematurity.
6. Decrease the incidence of mental retardation and congenital defects.
7. Improve the understanding of family life and human sexuality.
8. Avoid worsening present economic position and gain a higher standard of living for the family.

Planned Parenthood World Foundation reports that out of 5.3 million indigent women, only 850,000 or one in six are receiving family planning information.

According to Dr. N. H. Dyer in a recent issue of "State of the State's Health," there are an estimated 111,000 medically indigent females in West Virginia, ages 15-44 with incomes under $3,000. This would mean that about 19 per cent of the female population in the State is in the childbearing age. There are 42 counties in West Virginia where family planning and child spacing services are not available.

There are now nine counties conducting family planning clinics in West Virginia (Marion, Mason, Monroe, Putnam, Summers, Calhoun, Greenbrier, Wood, and Cabell Counties).

There is also a family planning clinic associated with the Maternal and Infant Care Project No. 504 at Morgantown and one associated with the Maternal and Infant Care Project No. 528 at Memorial Hospital, Charleston.

There are two clinics in Kanawha County, one at Chelyan and one in South Charleston. Another clinic is expected to be opened in Harrison County before the end of the year.

The most recent clinic is the new Project No. 777, a pilot family planning clinic in Ohio County, which will be in operation about September, 1969. It is planned that this clinic can be extended to Brooke, Hancock, Marshall and Wetzel Counties. It is the desire of the State Health Department to operate a family planning clinic for each county.

These clinics are available to any person living in West Virginia and all services shall be offered without regard to race, age, religion, nationality, marital status, or income, as long as the patient desires such services and cannot afford them.

Dr. Morgan of Charleston Wins Golf Tournament

Dr. William C. Morgan of Charleston shot a 77 to win the Annual Medical Golf Tournament which was conducted in connection with the State Medical Association's Annual Meeting at The Greenbrier. The runner up was Dr. Ernest Q. Hull of South Charleston, who shot a 78. Other low gross scores included: Dr. C. H. Hiles of Wheeling and Mr. William Booth of Charlottesville, Virginia, both with scores of 80, and Drs. Charles D. Cottrell, Jr., of Charleston and Jack Leckie of Huntington.

William C. Morgan, Jr., M. D.

Doctor Morgan won temporary possession of the beautiful championship trophy sponsored by the Hospital and Physicians Supply Company of Charleston.

Drs. W. E. Gilmore of Parkersburg, Joseph A. Smith of Dunbar and Robert R. Weiler of Wheeling tied for low net honors with scores of 72. Other low net scores included: Drs. George A. Curry of Morgantown, David A. Haught of Huntington and Joseph Gilman of Clarksburg, all with 73.

Dr. Wilson P. Smith of Huntington won the blind bogey and Dr. Donald M. Appleton of Portsmouth, Ohio, had the lowest number of putts with 30.

Dr. Joseph A. Smith of Dunbar once again was in charge of the tournament and presented the awards at the reception honoring the officers of the Association on Saturday evening, August 23.

Dr. Asa Barnes Is Appointed To UMW Post

Dr. Asa Barnes of Beckley, United Mine Workers Medical Director in Districts 17 and 29 for the past six years, has been appointed Deputy Executive Medical Officer of the International Union's Welfare and Retirement Fund.

He reported to his new office in Washington, D.C., on September 8 as Deputy to Dr. John Newdorp, Chief Medical Officer. Doctor Newdorp was promoted to that post upon the retirement of Dr. Warren F. Draper.

Succeeding Doctor Barnes in Beckley was Dr. James A. Barnes. The two physicians are not related. Dr. James Barnes has been in the District 29 office in Beckley for more than a year and has been in charge of the Beckley area under Dr. Asa Barnes since April.

Both physicians are members of the West Virginia State Medical Association.

Hospital Library Conference In Harrisburg, Pa.

A one-day conference entitled "The Hospital Library" will be held on October 23 at the William Penn Memorial Museum in Harrisburg, Pennsylvania.

The conference has been arranged by the Pennsylvania Medical Society and other sponsors for hospital administrators, hospital-based medical educators, directors of nursing education and in-service education directors.

Emphasis will be placed on the role the library must play in medical and health science education and scientific expansion.

A registration fee of $5.00 will be charged, and additional information may be obtained by writing to: Council on Education and Science, Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pennsylvania 17043.

Saturday, the final day of the Annual Meeting, brought beautiful weather, and the reception honoring the new officers was held outdoors on the terrace of Chesapeake Hall as planned. In left photo, Dr. George R. Callender, Jr., of Charleston (dark jacket), the newly elected President Elect, is congratulated by Dr. Richard E. Flood of Weirton, while Dr. Harry S. Weeks of Wheeling, the new Vice President, awaits his turn to greet Doctor Flood. At right, Dr. and Mrs. Joe N. Jarrett of Oak Hill greet a well-wisher. Dr. John A. B. Holt of Charleston is facing camera. Mrs. Jarrett is the new President of the Woman's Auxiliary to the State Medical Association.

For Dr. Thomas L. Harris of Parkersburg, (at right in left photo, center in right photo), the 102nd Annual Meeting had special significance. It was the 50th consecutive Annual Meeting of the Association he had attended. At left, he talks over old times with Dr. N. H. Dyer, State Health Director. At right, he receives the congratulations of Dr. Gerald Dorman, President of the American Medical Association, as Dr. Richard W. Corbitt of Parkersburg, retiring President of the Association, looks on.

Nutrition Seminars Scheduled At Five Colleges

A series of seminars and lectures in nutrition will be presented during the current academic year at five West Virginia colleges and universities under the sponsorship of the American Medical Association Council on Foods and Nutrition and local medical societies.

The program was begun five years ago, and the lectures are designed to stimulate undergraduate students to consider careers in the health sciences as well as to inform the audience of recent developments in the field of nutrition.

Fifty-five lectures have been scheduled in the 11-state area which includes West Virginia. Guest lecturers will include Dr. George Christakis, Associate Dean and Professor of Community Medicine at the Mount Sinai School of Medicine in New York; and Dr. Richard C. Bozian, Associate Professor of Medicine and Director of the Division of Nutrition at the University of Cincinnati.

Doctor Christakis' lecture is entitled "The Emerging Art and Science of Clinical Nutrition." He will present it at West Virginia State College in Institute on November 7, and at Bethany College in Bethany on November 12.

Doctor Bozian will speak at Marshall University in Huntington on December 4, at Morris Harvey College in Charleston on December 5, and at Concord College in Athens on March 4. Doctor Bozian's subject is "Nutrition, Genetics and Disease—Adaptive Responses in Man."

Albany Medical College Lists Medical Seminar Cruise

The Albany Medical College will conduct its 11th Medical Seminar Cruise next January.

Reservations are now being accepted for the 17-day cruise aboard the Swedish American Line ship *Gripsholm*. Ports of call include the Virgin Islands, Martinique, Barbados, Trinidad, Venezuela, the Netherlands Antilles, the Dominican Republic and Haiti.

A comprehensive educational program will be presented.

Information may be obtained by writing to the Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

Dr. Thomas J. Holbrook of Huntington (center in left photo), Chairman of the Section on Neurology, Neurosurgery and Psychiatry, is shown with two guest speakers: Dr. Ludwig Gutmann of Morgantawn (left) and Dr. Francis M. Forster of Madison, Wisconsin. In right photo, Dr. Richard W. Corbitt of Parkersburg (center), President of the Association, is shown with the Presidents of two sister state medical associations. At left is Dr. G. E. Farrar, Jr., of Philadelphia, Pennsylvania, and at right is Dr. Robert N. Smith of Toledo, Ohio.

Mrs. Joe N. Jarrett Installed As Auxiliary President

Mrs. Joe N. Jarrett of Oak Hill was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the Auxiliary's 45th Annual Meeting at The Greenbrier in White Sulphur Springs, August 21-23.

Mrs. Joe N. Jarrett

The meeting was held at the same time as the 102nd Annual Meeting of the West Virginia State Medical Association.

Mrs. John M. Chenault, President of the Woman's Auxiliary to the American Medical Association, was a guest of the State Auxiliary. She presided at the installation of Mrs. Jarrett, who succeeded Mrs. John A. B. Holt of Charleston as President.

Other New Officers

Mrs. Robert J. Tchou of Williamson was named President Elect. She will be installed as President during the 1970 Auxiliary convention next August. Other new officers for the coming year are as follows:

Mrs. M. Bruce Martin of Huntington, Vice President; Mrs. Herbert Stelling of Romney, Eastern Regional Director; Mrs. Myer Bogarad of Weirton, Northern Regional Director; Mrs. Harold Van Hoose of Man, Western Regional Director; Mrs. Robert G. Shirey of Lewisburg, Southern Regional Director; Mrs. Harvey Martin of White Sulphur Springs, Recording Secretary; Mrs. B. F. Puckett of Oak Hill, Corresponding Secretary; Mrs. William T. Lawson of Fairmont, Treasurer; and Mrs. A. J. Villani of Welch, Parliamentarian.

The following chairmen of standing committees were named:

Mrs. Louis W. Groves, Jr., of Richwood, AMA-ERF; Mrs. Pat A. Tuckwiller of Charleston, Archives and History; Mrs. William A. Thornhill, Jr., of Charleston, By-Laws and Handbook; Mrs. Robert G. Janes of Fairmont, Community Health and Service; and Mrs. George A. Curry and Mrs. Clark K. Sleeth, both of Morgantown, Convention Co-Chairmen.

Mrs. J. L. Mangus of Charleston, Editor of the State News Bulletin; Mrs. Joseph A. Smith of Dunbar, Circulation Manager of the News Bulletin; Mrs. J. Dennis Kugel of Charleston, Finance; and Mrs. William P. Sinclair of Wheeling, Health Careers.

Mrs. Charles H. Hiles of Wheeling, Health Careers Fund, 1969-1972; Mrs. Wilson P. Smith of Huntington, Health Careers Fund, 1969-1971; Mrs. T. P. Long of Man, Health Careers Fund, 1969-1970; Mrs. Joseph E. Ricketts of Huntington, International Health Activities; and Mrs. Robert O. Strauch of Wheeling, Legislation.

Mrs. Charles E. Andrews of Morgantown, Liaison to the Woman's Auxiliary to the Student American Association; Mrs. Kenneth Bailey of Fairmont, *MD's Wife;* Mrs. Buford W. McNeer of Hinton, Members-at-Large; Mrs. M. Bruce Martin of Huntington, Membership; and Mrs. J. E. Blaydes, Jr., of Bluefield, Mental Health.

Mrs. Harry Beard of Huntington, Necrology; Mrs. Lewis N. Fox of Beckley, Press and Publicity; Mrs. Charles Harrison of Clarksburg, Program; Mrs. Hu C. Myers of Philippi, Rural Health; Mrs. Charles L. Goodhand of Parkersburg, Safety-Disaster Preparedness; and Mrs. A. C. Esposito of Huntington, Southern Medical Councilor.

Special committee assignments included Mrs. Richard G. Starr of Beckley, Children and Youth; and Mrs. Salvador Diaz and Mrs. Francis Gaydosh of Wheeling, Home Centered Health Care.

Mrs. Robert J. Tchou of Williamson (left), President Elect of the Woman's Auxiliary to the West Virginia State Medical Association, looks on as Mrs. John A. B. Holt of Charleston, retiring President, presents the President's Gavel to the incoming President, Mrs. Joe N. Jarrett of Oak Hill (second from right). At extreme right is Mrs. John M. Chenault of Decatur, Alabama, President of the Woman's Auxiliary to the American Medical Association.

Mrs. John A. B. Holt of Charleston and Mrs. Rupert W. Powell of Fairmont are Past Presidents who will serve on the Board of Directors during the coming year.

Medical Advisory Board

The Auxiliary's Medical Advisory Board will consist of Drs. Richard W. Corbitt of Parkersburg, Mildred M. Bateman of Charleston, Clark K. Sleeth of Morgantown, Louis W. Groves, Jr., of Richwood, and Joe N. Jarrett of Oak Hill.

Inaugural Address

In her inaugural address, Mrs. Jarrett challenged Auxiliary members to "upgrade your country, your state and the medical profession."

She noted that "all three have been maligned lately. As doctors' wives, we have a unique role to play in all three areas by the example we set.

"Let our lives be a lesson in democracy as we work with our own children, their friends, various youth organizations, and the special groups we sponsor . . ."

She called upon the Auxiliary to "lead the way for a brighter tomorrow for us all," noting that "we must not close our eyes and minds to the ills of our society."

The new President expressed the hope that "all of you will return to your counties and set up a liaison between the auxiliary and the medical students and their families in your midst."

"Invite them to your homes," she suggested, "encourage your husband to have them observe how medicine is practiced here, and point out the values of living in West Virginia with its beautiful scenery, pleasant climate, and friendly people."

These members were among women who attended sessions of the 45th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association at The Greenbrier, August 21-23. Left to right: Mrs. Willis Garrard of Charleston, President of the Woman's Auxiliary to the Kanawha Medical Society; Mrs. Harvey Martin of White Sulphur Springs, Recording Secretary of the State Auxiliary organization; Mrs. Robert Shirey of Lewisburg, Southern Regional Director; Mrs. M. Bruce Martin of Huntington, Vice President; Mrs. Myer Bogarad of Weirton, Northern Regional Director; and Mrs. William T. Lawson of Fairmont, Treasurer.

Standing and Special Committees Named by Doctor Pride

Dr. Maynard P. Pride of Morgantown, President of the West Virginia State Medical Association, has appointed the following standing and special committees which will function during his one-year term of office:

Aging

Eldon B. Tucker, Morgantown, Chairman; Thomas H. Blake, St. Albans; Myer Bogarad, Weirton; E. Lyle Gage, Bluefield; Richard D. Hamilton, St. Marys; and Thomas H. McGavack, Martinsburg.

Cancer

Alvin L. Watne, Morgantown, Chairman; John J. Battaglino, Jr., Wheeling; F. Lloyd Blair, Parkersburg; Harry F. Cooper, Beckley; L. Walter Fix, Martinsburg; William E. Gilmore, Parkersburg; David B. Gray, Charleston; Ray A. Harron, Bridgeport; Hu C. Myers, Philippi; John J. Schaefer, Charleston; Charles W. Thacker, Parkersburg; John Wm. Trenton, Kingwood; and Chauncey B. Wright, Huntington.

Constitution and By-Laws

J. C. Huffman, Buckhannon, Chairman; D. E. Greeneltch, St. Clairsville, Ohio; Carl B. Hall, Charleston; Sobisca S. Hall, Clarksburg; James S. Klumpp and Jack Leckie, Huntington; Athey R. Lutz, Parkersburg; Richard V. Lynch, Jr., Morgantown; and L. J. Pace, Princeton.

Insurance

C. A. Hoffman, Huntington, Chairman; Robert L. Chamberlain, Buckhannon; R. U. Drinkard, Wheeling; A. C. Esposito, Huntington; F. Perry Greene, Parkersburg; Upshur Higginbotham, Bluefield; Kenneth G. MacDonald, Charleston; Buford W. McNeer, Hinton; and J. C. Pickett, Morgantown.

Interprofessional Relations

William L. Neal, Huntington, Chairman.

Sub-Committees

Medico-Legal: A. J. Villani, Welch, Chairman; S. William Goff, Parkersburg; and Paul H. Revercomb, Charleston.

Medicine and Religion: Tracy N. Spencer, Jr., South Charleston, Chairman; Dwight P. Cruikshank, Parkersburg; and V. L. Dyer, Petersburg.

Medicine and Pharmacy: R. C. Cowan, Jr., Parkersburg, Chairman; Andrew E. Amick, Lewisburg; John L. Fullmer, Morgantown; and L. Dale Simmons, Clarksburg.

Medical - Dental Liasion: George L. Armbrecht, Wheeling, Chairman; Alberto G. Capinpin, Charleston; and James A. Thompson, Clarksburg.

Nurses Liaison: W. Fred Richmond, Beckley, Chairman; Bert Bradford, Jr., Charleston; Wlida S. Joseph, Wheeling; and Thomas J. Tarnay, Morgantown.

Legislative

Frank J. Holroyd, Princeton, Chairman; J. E. Blaydes, Jr., Bluefield; John T. Chambers, Charleston; George A. Curry, Morgantown; Del Roy R. Davis, Kingwood; A. C. Esposito, Huntington; Paul E. Gordon, Clarksburg; D. E. Greeneltch, St. Clairsville, Ohio; N. B. Groves, Martinsburg; Carl B. Hall, John M. Hartman and John W. Hash, Charleston; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Jack Leckie, Huntington; Charles L. Leonard, Elkins; A. Thomas McCoy, Charleston; Paul L. McCuskey, Parkersburg; Charles W. Merritt, Beckley; David W. Mullins, Logan; Thomas G. Reed, Charleston, Joseph D. Romino, Fairmont; William B. Rossman, Charleston; Robert G. Shirey, Ronceverte; Page H. Seekford, Charleston; I. Ewen Taylor, Huntington; A. J. Villani, Welch; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; and Ward Wylie, Union.

Maternal and Perinatal Fetal Welfare

A. J. Villani, Welch, Chairman; Walter A. Bonney, Jr., Morgantown; Clarence H. Boso and Thomas J. Conaty, Huntington; Paul H. Cope, Wheeling; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; Thomas G. Folsom, Huntington; N. W. Fugo, Morgantown; George G. Gevas, Parkersburg; Robert Greco, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; A. Robert Marks, Clarksburg; Rose H. McClanahan, Charleston; Charles W. Merritt, Beckley; Thomas G. Potterfield, Charleston; Meryleen B. Smith, Peterstown; and Gates J. Wayburn, Huntington.

Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; K. D. Bowers, Jr., Morgantown; C. B. Buffington, Wheeling; J. Marshall Carter, Huntington; R. L. Chamberlain, Buckhannon; Henry R. Glass, Jr., Charleston; Joe N. Jarrett, Oak Hill; Jack C. Morgan, Fairmont; George Naymick, Weirton; W. H. Rardin, Beckley; George W. Rose, Clarksburg; H. R. W. Vial, South Charleston; Herbert E. Warden, Morgantown; and George W. West, St. Marys.

Medical Economics

Harry S. Weeks, Jr., Wheeling, and Worthy W. McKinney, Beckley, Co-Chairmen.

Sub-Committees

Federal Medical Activities: Richard V. Lynch, Jr., Morgantown, Chairman; Charles H. Barnett, Parkersburg; George R. Callender, Jr., Charleston; Forest A. Cornwell, Beckley; Daniel Hale, Princeton; Thomas J. Holbrook, Huntington; W. E. King, Morgantown; James T. Spencer, Charleston; and Charles W. Thacker, Parkersburg.

State Workmen's Compensation: Worthy W. McKinney, Beckley, Chairman; George R. Callender, Jr., Charleston; Rex Dauphin, Parkersburg; George V. Hamrick, Charleston; Thomas J. Holbrook, Huntington; Theodore P. Mantz, Charleston; Lawrance S. Miller and J. C. Pickett, Morgantown; and Clifford A. Stevenson, Beckley.

Blue Cross-Blue Shield Third Party: Charles E. Andrews, Morgantown, Chairman; Robert W. Bess, Jr., Piedmont; John M. Bobbitt and C. A. Hoffman, Huntington; Logan W. Hovis, Parkersburg; Ray M. Kessel,

Logan; Milton J. Lilly, Jr., Charleston; and Lynwood D. Zinn, Clarksburg.

Public Welfare-Joint Conference: Thomas P. Long, Man, Chairman; R. C. Cowan, Jr., Parkersburg; Richard E. Flood, Weirton; N. B. Groves, Martinsburg; John M. Hartman, Charleston; W. Gene Klingberg, Morgantown; A. Thomas McCoy, Charleston; W. Fred Richmond, Beckley; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Charles E. Andrews, Morgantown; Forest A. Cornwell, Beckley; Richard A. Currie, Morgantown; E. L. Crumpacker, White Sulphur Springs; Del Roy R. Davis, Kingwood; William E. Gilmore, Parkersburg; Daniel Hamaty, Charleston; F. A. Hamilton, Jr., Martinsburg; Robert D. Hess, Bridgeport; Upshur Higginbotham, Bluefield; George M. Kellas, Wheeling; John D. Lindsay, Jr., Fairmont; Richard V. Lynch, Jr., and David Z. Morgan, Morgantown; Herbert D. Proctor, Huntington; Thomas G. Reed, Charleston; Howard B. Sauder, Wheeling; Edwin M. Shepherd, Charleston; Wm. S. Sheils, Huntington; Richard G. Starr, Beckley; Grover B. Swoyer and William A. Thornhill, Jr., Charleston; and Halvard Wanger, Shepherdstown.

Medical Emergencies and Civil Defense

John J. Mahood, Bluefield, Chairman; Harold D. Almond, Buckhannon; Dominic A. Brancazio, Weirton; Harry F. Coffman, Keyser; Salvador Diaz, Huntington; Ernest G. Guy, Philippi; Charles H. Hiles, Wheeling; John A. B. Holt, Charleston, Donald R. Lantz, Parkersburg; John J. Lawless, Morgantown; Joseph T. Mallamo, Fairmont; John B. Markey, Charleston; James G. Ralston, Clarksburg; William S. Sadler, Barboursville; Lyle D. Vincent, Parkersburg; John W. Whitlock, Beckley; and E. Andrew Zepp, Martinsburg.

Medical Scholarships

Martha Jane Coyner, Harrisville, Chairman; Marshall J. Carper, Charleston; Robert D. Hess, Bridgeport; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; and John Mark Moore, Wheeling.

Mental Health

L. J. Pace, Princeton, Chairman; Mildred Mitchell-Bateman, Charleston; Delmer J. Brown, Parkersburg; Randall Connolly, Vienna; Roy A. Edwards, Jr., Huntington; Ray S. Greco, Weirton; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; William B. Rossman, Charleston; A. L. Wanner and Stephen D. Ward, Wheeling; Charles C. Weise, Charleston; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; Robert D. Hess, Bridgeport; and Logan W. Hovis, Parkersburg.

Program

Robert J. Fleming, Morgantown, Chairman; Charles E. Andrews, Morgantown; Thomas P. Long, Man; and A. Thomas McCoy, Charleston.

Public Service

Albert C. Esposito, Huntington, Chairman; John M. Bobbitt, Huntington; George A. Curry, Morgantown; C. R. Davisson, Weston; Leonard M. Eckmann, South Charleston; G. Thomas Evans, Fairmont; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; C. A. Logue, Morgantown; George E. McCarty, Parkersburg; Charles W. Merritt, Beckley; L. J. Pace, Princeton; Joseph B. Reed, Buckhannon; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; Stephen D. Ward, Wheeling; and A. J. Weaver, Clarksburg.

Resolutions

Richard V. Lynch, Jr., Morgantown, Chairman; Robert W. Bess, Jr., Piedmont; Richard E. Flood, Weirton; Albert C. Esposito, Huntington; Seigle W. Parks, Charleston; and I. Ewen Taylor, Huntington.

Rehabilitation

Buford W. McNeer, Hinton, Chairman; C. B. Buffington, Wheeling; Jean P. Cavender, Charleston; James A. Heckman, Huntington; Francis H. Hughes, Parkersburg; Ralph H. Nestmann, Charleston; J. C. Pickett, Morgantown; L. Dale Simmons, Clarksburg; Harold B. Sunday, Charleston; Vann S. Taylor, Beckley; Robert R. Weiler, Wheeling; and James Hugh Wiley, Morgantown.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; Holmes Blair, Parkersburg; Ralph H. Boone, Sistersville; B. S. Brake, Clarksburg; Robert W. Coplin, Elizabeth; Del Roy R. Davis, Kingwood; N. H. Dyer, Charleston; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; Robert R. Frye, Mannington; O. M. Harper, Clendenin; Mehmet V. Kalaycioglu, Shinnston; Charles T. Lively, Weston; Ralph McGraw, Follansbee; Joseph B. Reed, Buckhannon; and Charles E. Staats, Charleston.

Syphilis

N. H. Dyer, Charleston, Chairman; Hunter Boggs, Charleston; C. Y. Moser, Kingwood; Frank M. Peck, Huntington; David S. Pugh, Chester; Thomas L. Thomas, Wheeling; M. A. Viggiano, New Martinsville; Lyle D. Vincent, Parkersburg; and Isaiah A. Wiles, Morgantown.

Tuberculosis

Hugh S. Edwards, Beckley, Chairman; Charles E. Andrews, Morgantown; Robert M. Biddle, Parkersburg; J. M. Brand, Chester; Oliver H. Brundage, Parkersburg; William L. Cooke, Charleston; N. Allen Dyer, Bluefield; George F. Evans, Clarksburg; G. R. Maxwell, Morgantown; Ralph H. Nestmann and Morris H. O'Dell, Charleston; Robert J. Reed, III, Wheeling; M. A. Viggiano, New Martinsville; James H. Walker, Charleston; M. L. White, Jr., Huntington; and David H. Williams, Weirton.

SPECIAL COMMITTEES

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Irwin M. Bogarad, Weirton; Harry F. Cooper, Beckley; John E. Echols, Richwood; Robert J. Fleming, Morgantown; John H. Gile, Parkersburg; Joseph Gilman, Clarksburg;

Daniel Hale, Princeton, Robert W. Howes, Jr., Parkersburg; Joe N. Jarrett, Oak Hill; Buford W. McNeer, Hinton; David Z. Morgan, Morgantown; Jack C. Morgan, Fairmont; Earl S. Phillips, Wheeling; Donald R. Roberts, Elkins; George A. Shawkey, Charleston; Wilson P. Smith, Huntington; John W. Trenton, Kingwood; Lysle T. Veach, Petersburg; and E. Andrew Zepp, Martinsburg.

School Health

Peter A. Haley, Charleston, Chairman; R. J. Bailey, Parkersburg; J. M. Brand, Chester; Hugh M. Brown, Clarksburg; Thomas G. Folsom, Huntington; Grover C. Hedrick, Jr., Beckley; Robert G. Janes, Fairmont; Edward Shupala, Parkersburg; Paul C. Soulsby, St. Albans; Thomas L. Thomas, Wheeling; and Eli J. Weller, Weirton.

Cardiac Auscultation Course In Parkersburg

A one-day postgraduate seminar entitled "Cardiac Auscultation Review With Case Presentations" will be presented at St. Joseph's Hospital in Parkersburg on Sunday, October 19.

The course is being sponsored by the West Virginia State Medical Association's Committee on Medical Education and Hospitals, the West Virginia Heart Association and the Division of Cardiovascular Disease of the West Virginia University Medical Center.

Faculty will include Dr. Robert J. Marshall, Professor of Medicine and Chairman of the Division of Cardiovascular Diseases at WVU, Dr. H. Michael Dean, also of the School of Medicine, and internists from the Parkersburg area. Dr. William E. Gilmore of Parkersburg, Area Educational Coordinator for the Committee on Medical Education and Hospitals, is in charge of local arrangements.

A registration fee of $10 will be charged, and the American Academy of General Practice has accredited the course for four elective hours for its members.

Doctor Gilmore said that while the course is intended primarily for physicians in Tyler, Doddridge, Gilmer, Calhoun, Jackson, Wirt, Wood, Pleasants and Ritchie Counties, any member of the State Medical Association is welcome and encouraged to attend. An invitation has also been extended to physicians in nearby areas of Ohio.

The course will begin at 9:30 A. M., and should end by 3:30 P.M. The cost of a luncheon in the hospital cafeteria is included in the registration fee.

Advance registration is requested, and a course summary and registration blank appears on Page 335 of this issue of *The Journal*.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Oct. 2—Rural Health Conf., Jackson's Mill.
Oct. 6-10—ACS, San Francisco.
Oct. 8-12—Pa. Medical, Philadelphia.
Oct. 11-12—Am. Assn. of Oph., Chicago.
Oct. 12-17—Am. Acad. of Oph. & Otol., Chicago.
Oct. 16-19—Virginia Medical, Virginia Beach.
Oct. 18-23—Am. Acad. of Ped., Chicago.
Oct. 20-21—W. Va. Hosp. Assn., White Sulphur Springs.
Oct. 25-29—Am. Soc. of Anes., San Francisco.
Oct. 29-Nov. 2—Am. Col. of Chest Phys., Chicago.
Oct. 31-Nov. 2—Pot.-Shen. Val. PG Inst., Martinsburg.

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Detroit.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 4-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.

Feb. 8-9—AMA Cong. on Med. Ed., Chicago.

Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 31-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 13-17—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-30—Am. Ped. Soc., Atlantic City.

May 5-9—Am. Psychiatric Assn., San Francisco.
May 11-14—Am. Urological Assn., Philadelphia.
May 18-22—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.

June 21-25—AMA, Chicago.

July 17-18—Rocky Mtn. Cancer Conf., Denver.

Aug. 20-22—103rd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 11-19—Am. Soc. of Clin. Path., Atlanta.
Sept. 12-18—Col. of Am. Path., Atlanta.
Sept. 20-24—Am. Acad. of Oph. & Otol., Las Vegas.
Sept. 22-24—Ky. Medical, Louisville.
Sept. 25-Oct. 2—AAGP, San Francisco.

The West Virginia Medical Journal

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Let's Go, West Virginia!*

The Hon. Arch A. Moore, Jr.

The Author

- **The Hon. Arch A. Moore, Jr., Governor of the State of West Virginia.**

Thank you for permitting me to have this opportunity to be with you this morning.

It is always a pleasure for me to have the chance to renew my friendships and acquaintances with the many of you I have learned to know and to work with during my years as a Congressman.

I am all the more delighted to join with you today as it gives me an opportunity to share some thoughts on matters that should be of interest to you as doctors and as West Virginia citizens, and which are of particular concern to me as your Governor.

You can appreciate in between a special legislative session and the day-to-day commitments, The Greenbrier always seems to look more appealing and inviting than the last time. Maybe its the over-all atmosphere that makes it seem that way.

I know one thing—I don't know of a more conducive setting to improve the over-all condition of West Virginia's health than this fine gathering of experts who are dedicated to curing the ills of humanity.

For we know full well that unless we address our thoughts and actions to help build a better world for mankind, the conflicts will remain.

But the ageless goals for which we have yearned for so long can be achieved, when we lift ourselves together, limited only by our limitations.

While we have gained another world in the Apollo 11 feat, we cannot close our eyes to the realities of life today here on earth. We must dare to achieve the inconceivable—together. We cannot do it without teamwork, we cannot progress without the unity of purpose. We know what happens when this sense of concreted effort is hampered, diminished or eliminated.

We know what serious impediments the void of confidence brought upon West Virginia's rate of growth and self-improvement.

The physician may have termed it a coma. The sociologist, a state of deprivation. The economist, a condition of regressiveness. Regardless of the label, the conclusion—or diagnosis, if you will—coincided. As our youth would term it—West Virginia was really out of it.

All the symptoms were there. The afflictions were obvious. It didn't take a lab technician to probe under a microscope to discover the cause.

The deep-seated illness grew from a state government quickly deteriorating and eroding with crass mismanagement. The disease spread as the hopes of a persevering citizenry were constantly and blatently refused.

It infected the absolute right of a public to have the rewards commensurate with its hard-earned payment of taxes. The prognosis was evident—the State of West Virginia's health was waning to the point that any chance for revival seemed hopeless. But as doctors, I know you do not find it strange or odd for the exceptional, the unpredictable. You have seen and known of numerous cases where the patient, given up for lost, made a comeback that by all human explanation could only be termed a miracle.

Today, this same incredible will to live, to regain and start a new lease on life is spreading throughout our State.

*Presented at the First General Scientific Session of the 102nd Annual Meeting of the West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, August 21, 1969.

The medicines that have been administered to help sustain the spirited rally and to encourage further sound health, however, cannot have a permanent beneficial effect without the continued and wholehearted involvement of you—as doctors and as West Virginians.

While the few passing months indicate remarkable progress, each new challenge must be met and with it each new avenue it opens must be explored. We are in the middle of a crisis in attempting to hold down the soaring medical costs while at the same time providing effective and dignified care of all our people.

Hospital costs have increased from $44 a day average in 1965 to an average of $70 a day at present. It is expected to reach $80 next year, and in three years it could reach $100 a day. It is anticipated that the Medicaid program of health care for the poor alone could more than double its $2.5 billion annual cost in the next three years.

It is unfortunate, I might add, that because physicians dominate the practice of medicine, they are usually cast in the role as the villian in matters such as the federal health care program. I think it is of timely importance to balance the record in proper perspective.

Out of a total membership of 200,000 practicing physicians, only 572 have come under preliminary scrutiny as a result of their participation in the Medicare program. I am sure that a figure of 572 will be much less when it is all over.

I grant you, that in any organization or any profession—government included—there are always the few whose actions tend to tarnish the public respect for the whole. But, I for one, do not—nor do the people have firm reason to—go along with the presumption that the actions of a *few* reflect a *substantial* basis of regard for the *whole* medical profession.

The galloping inflationary trend unquestionably is one of the severest battles we have to arrest. For its effects on our health services are probably felt more intensely by more people in our State than any other facet of living.

With the high cost of living we sharply feel the increasing demand for more doctors. The acute shortage of doctors in West Virginia is all the more keenly evident as you personally experience the drain upon your work, your energies, and the little time you have for yourselves and your families.

But we must pull together to break the cycle that this shortage has imposed upon us. Recently, I read an article in which one of the West Virginia University School of Medicine graduates of this year's class was giving his views on the same subject. Incidentally, this young man, Dr. Donald Naegele, is one of nine out of the 56 medical school graduates who is interning in West Virginia. I think his views bear merit in light of the fact that he is a native of West Virginia.

The gist of his observation was this: We, as West Virginians, must learn to *sell* the advantages of our State—develop growing communities, growing industries, develop better schools, better roads, better cultural facilities, and an advanced socio-economic atmosphere. He summed it up by saying that it is the total picture that makes the difference.

Now, as doctors it may be something of a problem to visualize yourselves as salesmen—when you associate it with the conventional field of occupation.

But I think a good starting point is in the new recruiting effort the Association initiated this year. It is my understanding that the group arranged for five speakers to appear before the medical students at WVU to let them know there are exciting advantages to practicing their profession in West Virginia.

Even though the benefits of these efforts will not be realized immediately—at least not until after residency training—this is a step in the right direction. You are to be commended for taking this project on, and I hope that you will be able to broaden the activity, because this is something we desperately need to solve.

And as we move ahead on this tack and in the revision of the license requirements, it is essential that we give equal attention and new thought to upgrade the quality of our health facilities.

Often, it has been said that our State-trained doctors leave because of inferior hospitals. However, I think that is an oversimplification, because the competition of our hospitals with those out of state are closely matched in the pay scales. Part of the reason, however, does center on the lure of big cities and individual preferences.

Be that as it may, it is all the more important for us to let our young medical aspirants know that while we do not have all the varieties of attractions that big city life offers, they *do have* the rare opportunity to *set the pace* in making changes and trying new approaches in the improvement of better medical service.

Just to give you an example of the open-minded attitude that is generating a forward-looking approach is the agreement between Charleston's two largest hospitals—Memorial and General—to sponsor a joint study to determine the feasibility of merger under one management. That such a possibility would be considered is just as much to the advantage of the doctor as it is to the public he serves. In many respects, it is no different from what public demands have been expressing in support of a revamping of the State government.

This consolidation—if it does evolve—could be the way in which quality care can be expended at a maximum of efficiency with a control of costs. It might be a better means in providing teaching services which should attract badly needed doctors, nurses and other paramedical personnel. If nothing else, that such a move is being considered underlies the fact that the days have passed when we can expect one facility to maintain a constant level of expanded services single-handedly with subsequent rising costs, increased demands and population.

The trend of cooperative work has made the difference in the comprehensive health program of another facility. As you know, the Beckley Appalachian Regional Hospital has been given only provisional approval in its residency program in pediatrics. Here is a case where significant decisions on the part of the medical community and the lay leaders involved played a big role in bringing our State closer together.

As a result of a contract affiliating West Virginia University's Department of Pediatrics and the Hospital's Division of Pediatrics, the geographical barriers of Northern and Southern West Virginia have been eliminated.

The mutual effort in taking this step is another bright sign of progressive thinking and a constructive stride to expand the pediatric activities throughout our State from an educational institution.

There is another responsibility we must face, however, and that is in the anticipation of the small irritations. We cannot allow the small wounds to become larger and uncontrollable. No longer can we wait until an emergency or crisis exists before we take action.

The diseases that through the ages have crippled children are yielding to preventative vaccines. First, there was small pox. Then, there was diphtheria, whooping cough, polio, and presently German measles. In isolated cases, the treatment of German measles poses no serious problem for you as doctors. But the fact that it can build up to epidemic proportions—as it did in 1964 when it left nearly 20,000 children with incurable defects—demands a vast change of viewpoint.

It is through the unmerciful experience that was suffered then that we must do everything now to prevent another widespread occurrence. It is all the more mandatory in light of the prediction that another epidemic is anticipated for 1970 and 1971.

As of this month, a crash immunization program through the State Health Department has been initiated to cut down the rate of this harmful virus that flourishes among our youth—particularly those in kindergarten and the lower school grades. Through your cooperation and that of the nurses, we will be able to launch an attack to provide inoculations throughout the State.

There is another area of effort that we must improve upon. The total health picture of our State has many-sided relationships. One of them involves our food consumption. Often we have heard it said that we are what we eat. And in turn, what we eat is frequently affected by peripheral influences—our economic status, the kinds of food available, the interest in nutrition shown by our physicians, local authorities and by the education program available.

In a few weeks, we will soon learn the results of how West Virginia stands among 10 states in the first nutrition and hunger study ever conducted to assess our national status in this regard. More than 3,000 persons have been visited by a team of 31 physicians, dentists, lab technicians, nurses, nutritionists and clerks. The results of the survey into 14 of our counties are now being compiled. Whatever the conclusions, and regardless of the profile it represents, we must be open to using it as a valuable guideline to make new inroads in elevating the standard of living in our State.

We can no longer short-change ourselves or our children in thinking that the best we are doing now is sufficient for the next five or ten, or twenty years. The streamlining of governmental agencies that we have initiated—by itself—certainly is not enough. The fact that $50 million can be saved annually is a potent stimulant. But what will keep the heart pumping for an invigorated State is the support of the people to inject the changes to make government more responsive.

Believe me, I know the changes to make government more responsive. Believe me, I know the changes are long overdue, but we

ask your patience, your continued interest, and cooperation. I think you may find some glimmer of light already in that we have perked up and given a much-needed shot in the arm in the Workman's Compensation Department. Much of the direction we are taking in this agency can be credited in large measure to the counsel you have offered us individually and collectively.

Another area is in the Welfare Department. The sweeping reorganization now under way will make it more in tune with the needs of the people it serves and in line with what you, as taxpayers, can expect in better use of your earnings.

The restructuring of 27 area Welfare offices will save in the first year of operation $1.5 million and build to $2.5 to $3 million each year thereafter. The elimination of duplication in efforts and programs also signifies one-fourth of the sum total that the Management Task Force estimates can be realized in the general health and welfare areas of State government.

There also are other areas where the modernization of the State's governmental machinery is showing fast signs of a desire to get into fine fettle. We are beginning to realize now the value of the staggered system of distributing license plates; in terms of money—a quarter of a million dollars of annual savings; in terms of time—elimination of the constant aggravation of standing in block-long lines to get a license plate.

The $100 here and the $500 there are adding up to the thousands that will be better utilized in phasing out farm operations under the State Mental Health Department.

The dollars and cents add up to quite a large sum of money when data processing techniques can incorporate the time-consuming and unnecessary spending for the numerous bookkeeping techniques in the Health Department.

With this new lease on life in West Virginia, we have upgraded the national ranking of our public school teachers as a result of a $27 million annual salary increase. This has pushed us up from 44th to 24th.

Because the people have let it be known quite clearly to their representatives and to this administration that they intend to get this State in the pink of health, we have seen giant efforts taken to create more opportunities for better economic opportunities. Within the past few weeks, two companies have announced they will locate new plants costing nearly $40 million and employing anywhere from 450 to 600 persons.

More industry will be looking at us now with a different and more appreciative attitude—now that we have let them see, through our actions with the tax credit plan—that they are welcome. With new plants come new people, who have the same needs and wants as ours. Schools, homes, good roads, fine medical services and the feeling of hospitality that only their environment and their neighbors can accurately convey. So we cannot wait until industry actually moves in. We must take action now.

The road building program that has been launched since this administration took office is continuing at the same fast pace of work. We do not intend to allow for one penny to be wasted in the construction dollar nor are we going to let another year to roll by before we get going on our primary and secondary road improvements.

In eight years, only 180 miles of the Interstate Highways have been built. Talk about a challenge! We have 330 miles to go yet in that phase of road construction. Our Appalachian Development Highway allotment is 456 miles. We are faced with the goal of constructing the whole bundle. We can do it, and we are determined to get it done as quickly and as efficiently as possible.

So, it all goes back into your hands. We can only push forward as much as you are willing to shoulder your share of the effort. The times offer us unprecedented opportunities for daring adventure.

In the matter of education, we have moved up in our teachers' salaries and certification categories in our public school system. But we still have a long way to go.

—Only 30 per cent of the students who enter ninth grade make it through graduation.

—Only 11 elementary schools in the entire State have guidance counselors.

—Only six counties have public kindergartens.

—Only 35 per cent of the high school graduates go to college and 20 per cent of those who don't, cannot find jobs.

In nursing, a report just released shows that West Virginia is in dire need of more than 500 nurses to meet a goal of 375 per 100,000 population. Tied closely with this acute shortage is the similar problem you have experienced in recruiting new doctors—the migration of new graduates to other states.

We have plugged the drain on the exodus of our public school teachers. But, I ask you, what do you suggest that we do—not as doctors, not

as State government—but as West Virginians to surmount these challenges I just mentioned?

Last Wednesday I was privileged to attend the President's State Dinner honoring the three brave men of the Apollo 11. One of the incidents that really impressed me had nothing to do with the applause and accolades that prevailed throughout the evening.

It was a moment that sort of helped to balance out the exhilerating mood. Astronaut Frank Borman, who commanded the Apollo 8 Mission, was asked if it were true he was retiring from the Space Program.

In his answer, Borman revealed his plans to contribute his energies now to making some break-throughs in exploring the ocean's depths, in attacking the overwhelming environmental problems that plague our nation's city and rural dwellers, in matters which he facetiously described as the "more mundane."

I think Borman put the challenge beautifully. And therein lies the paradox in the fantastic achievement of man's power and ability to lift himself and probe another world.

The incredible achievement of Apollo 11 clearly shows what human beings can do when we set our minds to it. Will we devote effort to cure the diseases, to develop excellent education opportunities, to eliminate hunger?

If the spirited desires and endurance of the West Virginian can serve as a basis of hope, then I say, there is no limit in the miracle that we can perform here in this great State of ours.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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An Outline of Action*

Gerald D. Dorman, M. D.

In the barely more than a month that I have been President of the American Medical Association, I have been asked several times, "To what extent do you believe you speak for all physicians?"

There is no positive answer to that question. Opinions vary widely among physicians on about any subject you can name, which is as it should be in a democratic organization.

But on one topic, I believe there is a unanimous point of view among the AMA's more than 200,000 members—and among the 300,000 physicians in our nation. That topic is our profession's determination to bring the best possible medical and health care to the people of the United States . . . and I mean to all of them.

Health care for all is a subject to which all of us owe a great deal of our time and effort, because it is a matter of primary concern to our nation. Government alone cannot solve the many problems. President Nixon made that clear in July when he asked for the help of the private sector of medicine.

At our convention in New York, I accepted his invitation wholeheartedly. I repeat my acceptance now. In so doing, I would like to restate three goals which can help lead to solutions of all the health care problems of our nation.

First is a constantly advancing health care system.

Second is development of widespread recognition and respect for the contributions and leadership of our profession.

Third is an enhanced functioning of the medical profession.

Let's begin with the need for an advancing health care system in America. The first requirement for success in meeting that goal is that the system be based on freedom of opportunity and personal incentives. A proper understanding of the need for incentives in health care is paramount to everything else.

Incentives are needed for people to stay healthy and avoid the need for medical care by living the kind of life that will maintain their health at a high level.

Incentives are needed for physicians, hospitals and allied professionals to increase care while holding down costs.

And incentives, to a profession like ours, are not only monetary or material. They include the friendship and appreciation of fellow human beings. They include the satisfaction of doing something constructive and the joy of achieving results in benefits to the community. And they include the realization of having done something worthwhile for this generation and for those to follow.

Whatever the incentives might be—and they must be discovered and developed, for they are not obvious—they must be a part of our health care system to make it dynamic. Advances in the science and art of medicine are useless if the system of delivering quality health care is atrophied or undermined.

Health Careers for Young People

As a part of improving the system, we must find the proper incentives to attract young people into health careers. We must find ways of using them to reserve the physician for activities that he, alone, can perform. But we also must keep our allies employed at a level that challenges their abilities and gives them, also, the satisfactions of a good job well done.

Our second goal is to develop widespread recognition of the contributions and leadership of our profession. We know that it is in the best interests of the nation that physicians strengthen their leadership in all matters pertaining to health care. To do so, however, we must perform at a height beyond any level ever before achieved.

Our leadership must be earned. It will not be bestowed upon us just because we think we ought to have it. The public needs and wants

The Author

- **Gerald D. Dorman, M. D., President, American Medical Association.**

*Presented during the First Session of the House of Delegates, 102nd Annual Meeting of the West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, August 20, 1969.

our medical care. But greater respect must be fostered if we are to do the tremendous job that lies before us.

To develop that respect of our leadership, we must create innovations in delivery of health care. We must improve our efficiency. We must develop the highest possible level of ethics and self-discipline. That means we must maintain a visible sincerity and dedication. We also must produce a high quality of professional service.

The medical profession can no longer tolerate a physician who gets behind in his scientific homework. It can no longer tolerate a physician who looks on medicine as a livelihood rather than a profession. It can no longer tolerate any medical society that concentrates on the private interests of its members, to the neglect of the problems of health care for all citizens. And it can no longer tolerate any institution designed to provide health care that ignores economies and efficiency.

Better Communications Needed

Our third goal is to enhance the functioning of our profession through increased and better communications within the profession—with all of our allies—and with the public and all of its organizations, including government.

We must help develop a better understanding of what can be done, what is not needed and what is not practicable. We must develop a better understanding of what the responsibilities are, not only of the physician, but of the patient himself—of the government—and of all others involved.

Those are the approaches I see us taking to solve the problems of health care: advancing our health care system; enhancing the performance of our own profession; and developing greater respect for the leadership we can offer.

Now let us turn to what some of the problems are that must be solved.

Quality of Medical Care

I'll start with the quality of medical care. If any one subject is more important than any other, this one is it. The methods of delivering care, the organization of providers, the financing or the facilities make little difference if the quality of care received by the patient is not good.

All of us believe that only physicians are really qualified to judge the competence of other physicians. Because we believe that—and even more because it's true—we must accept and discharge the responsibility of looking carefully over one another's shoulders to make sure medical care continues to get better—regardless of circumstances, facilities, financing or anything else.

The ever-present threat, of course, is that if physicians fail to audit their colleagues, establish standards and demand that they be met, then others will do the job for us. And no one can say what criteria they might use or how close those criteria would be to what we consider valid measurements of medical excellence.

Another subject that springs from peer review is what to do about physicians who cheat on government financing programs—by giving poor service, by over-charging, by charging for services not given or any other way.

The answer to this one is easy, if we're willing to do it. We can't sit by and wait for somebody else to find the cheaters. It is up to us to take the lead in rooting them out and condemning them.

Health Care for the Poor

A third major subject is medical and health care for the poor.

Two actions in particular at the July meeting of the AMA pertain to this subject. For one thing, the House of Delegates put to rest the continuing argument as to whether or not health care is a right.

The AMA has now resolved, first, "that it is a basic right of every citizen to have available to him adequate health care. Second, that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care. And, third, that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

The House also adopted a report of the AMA Board of Trustees' Committee on Health Care of the Poor. The report—now the policy of the AMA—emphasized "our strong commitment toward expanding nationwide programs to improve the health of the poor" and stated that "the same quality of medical care should be accessible to all people."

The report listed concepts to be included in AMA programs.

First, providing comprehensive health care to the poor is a desirable goal and must be a continuing program, identifying both short—and long—range activities.

Second, the AMA's purpose must be to implement the research already done on unmet needs for health services.

Third, any program must provide for participation by the poor in planning projects for their own communities.

And finally, physicians should work with other organizations, in and out of the health field, that are concerned with improving health care of the poor. The adopted report stated clearly that dynamic action in this field must have top priority in the AMA activities.

Before the annual convention, the AMA had already recommended that local medical societies carefully review the use of hospitals and nursing homes, since many patients can be well cared for as outpatients or in less expensive rest homes.

Another recommendation was that medical societies and physicians take health services into low-income areas where they are more convenient and less expensive.

Proposed Income Tax Credits

Ultimately, of course, we can hope that the nation will adopt the AMA proposal of income tax credits or government vouchers with which people of little or no income can purchase approved programs of voluntary health insurance.

Family Health Education

Problem number four in my necessarily brief list seems fairly minor to some persons. But I consider it very important. It is family health education for young people.

I feel strongly that the medical profession has a serious obligation to see that young people are given carefully prepared supervised and professionally delivered courses in growth, development and sex education as described by the House of Delegates in July.

Fifth is maternal and child care, a field in which the most positive action is being taken by the medical profession with neither guidance nor financial help from the government.

The goal of the Trustees' Committee on Maternal and Child Care is to be the national clearing house of information on maternal and infant mortailty. Information will come from local and state medical societies, state boards of health and many other sources.

Virtually every maternal or infant death is to be reviewed by members of local committees, who then report to the national group. Bringing together all data sould make the AMA the nation's leader in the area of encouraging more local activity and improving the quality of care throughout the country.

Delivering Health Care

Sixth and final is the problem of developing the best methods of delivering medical and health care.

Persons outside of our profession keep looking for a single plan that will solve all of the problems of manpower, productivity, cost and so forth.

One such plan is to center all health care in hospitals and their satellite institutions. Supporters of that idea overlook the fact that the cost of hospital care is the biggest factor in rising costs—and that the vast majority of care is provided outside of hospitals.

Another plan would put all health personnel into pre-set patterns or groups, with rigid cost controls. Such fixed patterns and controls would quickly freeze a system that has been marked through centuries of progress by innovation and improvement made possible only by flexibility and incentives.

We know that medical attention must be oriented to the patient—not to an institution. To a large extent the psychological well-being of the patient determines his state of health and influences the progress of his treatment.

Whatever system—or whatever multitude of systems—of delivering health care may finally come into being, there must be a relationship of mutual confidence and mutual respect between a patient and his physician.

People do not respond warmly and humanly to institutions. Such a response comes only from satisfying contact with a fellow human being.

This is by no means an exhaustive list. But I think if those six problems are taken care of, we will have made gigantic strides toward solving all problems that now exist in health care.

Quality of Medical Care

I urgently invite your participation in doing what must be done to assure the quality of medical care—to expose and eliminate the medical delinquent—to provide good medical and health care for the poor—to support competent health education for our young people—to improve maternal and child care—and to devise the best possible systems for delivering high quality health care to all of our patients.

All of those, as health matters, require action. All of them, as health problems, demand solutions. I am confident the solutions will come and that they will come principally through the programs of the AMA and all of the medical profession and its allies.

If our profession is to be truly successful in providing leadership to solve the problems of health care, most of the action programs will have to come from state and local medical societies rather than directly from the AMA.

The problems are local. To be effective, solutions also must be developed and applied on a tailor-made basis locally. Both the physicians and all the people of each local area must work together.

We know that any plan for health care must be flexible so that methods of care not only can change and improve, but can be focused sharply to meet specific situations. Flexibility is possible only if each area seeks its own answers to its own questions.

A national, monolithic plan providing a uniform health care system across the country will be just as bad if it is devised by the medical profession as it will if devised by the federal government or anyone else.

Watch-Dog Committees Needed

Among the steps that must be taken by individual physicians and local medical societies are stricter requirements of competence—common-sense safety programs with respect to the design and use of medical equipment—watch-dog committees that will not hesitate to limit or remove the hospital privileges of careless or incompetent physicians.

Closer scrutiny over the qualifications and functions of allies who help physicians—insistence that physicians keep up with medical advances through continuing education—assurance that no physician tries a procedure for which he is not fully qualified—an insistence that physicians consult with experts when consultation is called for.

These things cannot be overseen from any national office, in Washington or in Chicago. They can only be done within the local professional community.

What kind of things might be done? Let me give you just one example out of many that could be cited.

In connection with health care for the poor, the Chicago Medical Society has announced its plan to spend $250,000 to establish clinics in the slum neighborhoods of its city.

I am sure we shall see a great deal more of this kind of activity.

That is the kind of action, taken at the local level, for the benefit of people within the community, that will show our dedicated efforts to advance the health care system—and to enhance the performance of our own profession.

At the same time, it is activities of that sort—and only activities of that sort—that will develop public and governmental respect for the leadership we can offer in solving the problems of health care in every locality of this nation.

Privileged Communications — Obsolete?

THE large number of medical forms and reports required as part of our service to patients poses a constant, serious threat to confidential relationships.

Many medical reports are thoughtlessly and improperly sent through non-medical channels where serious violations of confidence take place. An employer is never entitled to know more than the fact of his employee's inability to work, the estimated time of return to duty and, perhaps, the existence of any contagious factor. Many physicians have encountered circumstances when revelation of the diagnosis has not been in the best interest of the patient.

Some educational systems actually require that a diagnosis be phrased in equivalent non-medical terms on their certificates of illness. The reason for this is of course very obvious. These certificates are often handled carelessly and result in frank breaches of confidence. Similar infringements of privacy by other agencies are becoming more and more frequent.

Even in the face of a patient's lack of concern for such violations, it is nevertheless our responsibility to protect him. The confidential nature of our relationship with patients will become extinct only if we permit it.—*Westchester Medical Bulletin.*

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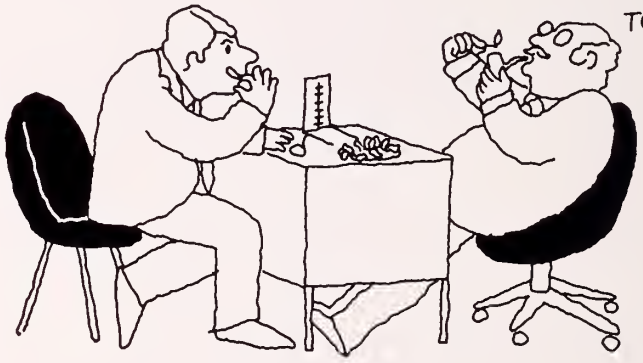

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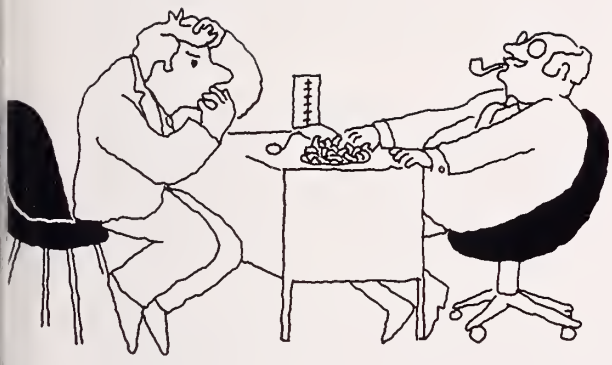

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Management of Immediate Postpartum Hemorrhage

Nicholas W. Fugo, M. D.

A leading cause of maternal morbidity and mortality is postpartum hemorrhage. Furthermore, the resultant anemia is an important complicating factor in many of the disorders of the postnatal period. While many cases of postpartum hemorrhage are unavoidable, some are the result of errors in management of the delivery. Most of us have at some time been guilty of mistakes in judgment which have resulted in excessive blood loss.

By definition postpartum hemorrhage is the loss of at least 500 ml. of blood attending a delivery. In most cases the tendency is to grossly underestimate the amount of bleeding so that the actual blood lost is many times greater than the recorded amount.

Predisposing Factors

Many factors tend to contribute to the development of postpartum hemorrhage. Awareness of the ever present possibility, with proper measures available for its prevention, will result in a marked decrease in morbidity and mortality.

Prolonged labor is responsible for many cases of hemorrhage. As labor continues the myometrium tends to become fatigued. Consequently, inertia may develop to the point of atony, with increased blood loss. Whether the prolonged labor be due to fetopelvic disproportion or an inadequate labor mechanism, difficult deliveries usually are a consequence. Operative obstetrics with relatively difficult forceps and large episiotomies also contribute to excessive blood loss.

Multiparity, too, can be a factor in postpartum bleeding. As parity and age increase there is a corresponding increment in connective tissue of the corpus making uterine atony more likely.

Overdistention of the uterus whether it be due to multiple gestation or hydramnios should always alert the physician to the possibility of hemorrhage following delivery. An overdistended uterus frequently fails to contract properly.

The induction of labor utilizing oxytocic drugs will sometimes result in excessive loss of blood postpartum. The most logical explanation is that all the factors responsible for the spontaneous onset of labor are not present. Consequently, the uterus fails to react normally.

The Author

- **Nicholas W. Fugo, M. D., Professor of Obstetrics and Gynecology, West Virginia University Medical Center, Morgantown.**

The history of postpartum hemorrhage in a previous confinement must always alert the physician to the possibility of its recurrence. This is especially true when the bleeding cannot be attributed to known factors such as trauma of the birth canal or uterus.

Precipitous labors frequently are associated with postpartum bleeding. Cervical, vaginal and perineal lacerations may occur which bleed excessively and are sometimes difficult to repair.

The use of heavy sedation or general anesthesia may result in uterine atony and uncontrolled hemorrhage. Usually unrecognized as a cause of hemorrhage is the excessive use of local anesthesia containing epinephrine. If large amounts of these substances are used, as much as 0.25 mg. of epinephrine may be administered. With this amount there is, in some cases, inhibition of uterine contractions with blood loss postpartum. In the same manner, a patient who is extremely apprehensive or frightened may release sufficient epinephrine to produce uterine atony and hemorrhage.

Preventive Measures

Many cases of postpartum hemorrhage can be avoided by strict adherence to proven obstetrical principles. One of the most important of these is slow extraction of the infant. This appears to be a minor point but with slow delivery there is ample time for the uterine musculature to contract, closing off the vascular sinuses with placental separation and diminished blood loss. This simple procedure is even more important than the use of oxytocins in obstetrical practice. The mode and time of administration of the oxytocin may vary with the physician and is not of prime importance. It can be administered intravenously or intramuscularly before or after delivery of the placenta. Its major purpose is to ensure a contracted uterus for a prolonged period after delivery.

Probably the best method with cephalic presentation is administration of 0.2 mg. of ergonovine maleate intravenously after the anterior shoulder stems under the symphysis. Objections to giving the oxytocin at this time are fear of placenta entrapment or failure to recognize a second twin. Occasionally with conduction anesthesia elevations of blood pressure will occur with ergonovine. If the patient is hypertensive during delivery, it probably is safer to administer pitocin or syntocinon in the dosage of 4 U intravenously. The advantage of using ergonovine is that the resulting contractions are more sustained and continue over a longer period of time.

Entrapment of the placenta occurs most frequently when the infant is delivered rapidly. A retained placenta need not be a serious complication since repeated studies have demonstrated that invading the uterus with sterile technique to manually remove the placenta can be done safely. Very little experience is needed for this procedure. With one hand in the uterine cavity and the other supporting the corpus through the abdominal wall, the plane of cleavage between the placenta and the uterine wall is found and the placenta gently wiped off. Care should be taken not to gouge the placenta since it can be torn in this manner and portions of cotyledons will remain.

When the oxytocin is given with delivery of the anterior shoulder and followed by slow delivery of the infant, eversion of the uterus is virtually impossible. In response to the oxytocin, the uterine wall is so thickened and the volume of the lumen so decreased that it cannot be turned inside out.

Some obstetricians recommend routine manual exploration of the uterine cavity following delivery. Their purpose is to ensure an intact uterus and to confirm complete removal of the placenta. While this procedure is essentially without risk when done under aseptic conditions, it is not essential following normal uncomplicated delivery provided both the maternal and fetal sides of the placenta are inspected for completeness. If a portion of the placenta appears missing, manual exploration of the uterus should be done.

The error is occasionally made of removing the placenta when the uterus is devoid of tone as occurs with deep general anesthesia. Profuse bleeding usually results. If this is the situation, the patient should be allowed to awaken to the point where uterine tone is restored. This can be aided by manual massage. If bleeding from the uterus occurs before delivery of the placenta and after delivery of the child, there should be no hesitancy to invade the uterus to remove the placenta.

The uterus should be thoroughly explored manually routinely in all cases of complicated delivery: breech, difficult forceps, forcep rotations and the like to ensure that uterine rupture has not occurred.

The entire birth canal and cervix should be explored with adequate exposure, at every delivery. Spontaneous delivery is no insurance against lacerations since they occur regardless. All bleeding areas must be repaired. Usually one or two figure-of-eight sutures will suffice but in some instances in which the tissue is highly vascular, friable and edematous and no arterial bleeding is involved, it is wiser to use pressure in the form of a gauze pack to control the hemorrhage rather than attempt to suture, since suturing may only exaggerate the condition.

There are occasions when the judicious use of cesarian section can prevent excessive blood loss. It is wiser to perform an abdominal delivery than to undertake a difficult, traumatic vaginal delivery which may be accompanied by hemorrhage as well as produce irreversible damage to mother or child, or both.

Precautionary Measures

There are a number of precautions which will act as insurance against development of serious postpartum hemorrhage. If sufficient help is not available starting an intravenous drip of five per cent dextrose in water before delivery is of great help. Oxytocin drugs can be added easily after delivery if bleeding persists. It also may be used as a convenient tap for withdrawing blood or for administration of various other medications. There should be available adjacent to the delivery area, Group O Rh negative blood and human fibrinogen for rapid replacement should it be necessary. When using intravenous oxytocin postpartum, the drip should be continued for at least four hours to ensure that the thrombi in the uterine sinuses are sufficiently fixed so that bleeding does not recur. Pitocin or Syntocinon should be used; Pitressin has no place in obstetrics.

There are occasions when the patient continues to bleed in spite of a continuous drip of oxytocin. In these cases proper packing of the uterus may be necessary. There are obstetricians who claim that packing should never be done, but the judicious use of packing may prevent the loss of a valued uterus. Certain reservations, however, must be adhered to when packing is contemplated. It should be done only once. If bleeding through the pack occurs other means

must be taken to stop the hemorrhage. The pack must fill the fundus snugly without overdistention and should include the vagina. It should not be done until all other means, short of surgery, to stop the bleeding have been tried. If there is a coagulation defect, fresh whole blood or human fibrinogen must be given in adequate amounts.

Once the uterus is packed, preparation for surgery must be undertaken. The scrub nurse should be alerted and the operating room readied. Additional help must be made available. Their preparations should not await evidence of further bleeding. It may be necessary to perform a uterine or hypogastric artery ligation or even hysterectomy. Time must not be lost and the patient's condition permitted to deteriorate. Time in these circumstances is of utmost importance.

It must be remembered that while all postpartum hemorrhage cannot be avoided, attempts to prevent it will decrease the amount of blood lost and consequently diminish the postpartum complications which result from severe anemia. Any effort which results in healthier mothers means healthier babies, and a better new generation.

To Physicians in Training

To all physicians in training and especially West Virginia residents: West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal will* receive individual and immediate attention.

Cardioversion*

Bernard Lown, M. D.

It has been six years since the introduction of cardioversion as a method for terminating arrhythmias. To date many thousands of patients have been successfully treated. This extensive experience provides an adequate basis for assessing the advantages and limitations of cardioversion. Ectopic tachycardias in the past have been controlled by means of drugs. The use of anti-arrhythmic agents, however, presents a number of limitations. To reach an effective dose requires a time consuming biologic titration involving frequent if not continuous monitoring of patients. However, whatever the precautions, serious side effects frequently occur. Furthermore, all anti-arrhythmic drugs when given rapidly or in large doses or when administered intravenously, depress myocardial contractility and reduce peripheral resistance. This may prove especially dangerous in the presence of an arrhythmia which already has compromised cardiac reserve.

Method and Rationale

The majority of human tachyarrhythmias are self-sustaining by virtue of recirculation of an excitable stimulus over a fixed or variable pathway. When the pathway is blocked, the ectopic mechanism is extinguished and the sinus node resumes its usual role as dominant pacemaker. Such block can be induced by an electrical pulse which depolarizes the entire heart and thereby abolishes momentarily all excitable activity. The hazard of electrical shock, namely, cardiac asystole and ventricular fibrillation, can be prevented by the use of brief direct current (DC) pulses and by discharging these pulses into a safe part of the cardiac cycle. The dangerous part of the cycle is the vulnerable period occurring at the time of inscription of the apex of the T wave. Electrical energy triggered into the heart during the vulnerable period results in ventricular fibrillation. Transthoracic DC shocks synchronized to discharge outside the T wave are both effective and safe for terminating a diversity of arrhythmias.

The Technique of Cardioversion

Since the most common disorder treated with cardioversion is chronic atrial fibrillation, the steps to be described apply especially to this arrhythmia. However, the same procedure with but slight modification is applicable to other ectopic mechanisms. In the case of elective reversion, the patient is started one to two days before the procedure on maintenance quinidine therapy in a dose of 0.3 gm. (5 gr.) 6 hourly. The objective of administering quinidine is fourfold: (1) to develop adequate serum and tissue levels in order to prevent prompt recurrence of the arrhythmia; (2) to determine whether quinidine is well tolerated; (3) to obtain a small dividend of reversions observed in about 10 per cent of patients with chronic atrial fibrillation while on maintenance quinidine therapy; and (4) to diminish the incidence of ectopic mechanisms immediately following cardioversion. One hour before the procedure 0.1 gm. pentobarbital sodium (Nembutal[R]) is given orally. Transient amnesia is achieved by use of diazepam (Valium[R]) given in a dose of 2.5 mg. intravenously and repeated at two minute intervals until mild anesthesia. This drug is well tolerated and generally about 10 to 15 mg. suffices for the desired effect. The two electrode paddles are coated with liberal layers of conductive paste and applied in a front-back orientation. The anterior paddle is held with pressure on the mid sternum while the patient lies on the posterior paddle which is located in the left infrascapular region.

Perhaps the most important aspect of the procedure is to begin with low energy settings of 1 to 5 watt seconds (WS) and then proceed with higher energies such as 25, 50, 100, 200, 300, up to 400 WS. The practice of energy titration protects against serious complicating arrhythmias. For example, if electric shock provokes ectopic beats at low energies before reversion is achieved, one has the option of postponing the procedure or else administering lidocaine in a bolus of 50 mg. intravenously. If such titration is carried out, it is not necessary to discontinue

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digitalis drugs prior to cardioversion. The reversion itself takes but a fraction of a second and the patient is usually awake within a few minutes. When a normal mechanism is restored blood pressure generally rises. There is no need to monitor the patient for a period longer than one hour if the procedure is uncomplicated.

Selection of Patients

How are patients to be selected for cardioversion? Two questions need to be answered: (1) is the arrhythmia susceptible to electrical reversion? and (2) will a normal mechanism be maintained for a sufficiently long time? Cardioversion has no place in the treatment of brief paroxysmal arrhythmias, recurring ectopic beats or deranged atrioventricular or intraventricular conduction. It is without effect when the mechanism is sinus tachycardia, a reflex physiological acceleration of the normal pacemaker which does not yield to antiarrhythmic measures. Digitalis induced rhythm disorders similarly are impervious to cardioversion. Furthermore, in the presence of digitalis toxic arrhythmias, more serious and even fatal disorders of the heart beat may result.

A number of patients are poor candidates for cardioversion because though sinus rhythm can be established it cannot be maintained. When quinidine is not tolerated and adverse reactions follow procaine amide, a normal rhythm will not persist. Patients with rheumatic heart disease who have been in continuous atrial fibrillation for more than two years or those with advanced degrees of mitral regurgitation who display a giant left atrium are unlikely to remain in sinus rhythm long enough to justify cardioversion. The elderly asymptomatic patient with coronary artery disease and atrial fibrillation who exhibits a slow ventricular rate prior to digitalization is an unsuitable subject. Patients who have recurrent paroxysm of diverse atrial arrhythmias should not be reverted once they develop atrial fibrillation. They are less symptomatic with atrial fibrillation than when in sinus rhythm punctuated by frequent paroxysms of tachycardia. Patients should not be reverted before, during, or immediately after valvular operations. It is preferable to wait for 10 or more days after surgery since sinus rhythm is then more likely to be long lasting.

Overall Results

To date at the Peter Bent Brigham Hospital 900 patients have been reverted by means of cardioversion. Chronic atrial fibrillation accounted for 650 of these episodes; 150 had atrial flutter and the remaining 100 had either ventricular tachycardia or varying supraventricular mechanisms. The overall success rate was 95 per cent. These results are the more impressive, since the arrhythmia in many of these patients had proved refractory to large doses of antiarrhythmic drugs. More than 2,000 electrical shocks were employed; yet, there was not a single episode of prolonged cardiac asystole and but one episode of ventricular fibrillation due to a failure to synchronize the shock. Although many of the patients were in critical condition and a number had sustained acute myocardial infarction and were in far advanced stages of congestive heart failure, none died as a result of cardioversion. Serious immediate complications were limited to 10 episodes of ventricular tachycardia. These were of brief duration and readily controlled. Eight of the patients suffered systemic thromboembolic complications within one to eight days following cardioversion.

Specific Rhythm Disorders

Atrial fibrillation is the most common chronic disorder of the heart beat. One is no longer justified in using quinidine for reversion of this disorder. With quinidine, even when given in large doses, only 50 per cent of patients are restored to sinus rhythm; however, 30 per cent experience significant toxic reactions and one to two per cent may die from the drug. With cardioversion, atrial fibrillation can be terminated in more than 90 per cent with an incidence of complications not exceeding one per cent.

Immediately after the cardioversion discharge, there may be transitional mechanisms consisting of nodal rhythm, a shifting pacemaker, and ectopic atrial beats. These are observed in about 50 per cent of patients and continue for 30 to 60 seconds until the sinus node "warms up." With restoration of sinus rhythm, the ventricular rate is slowed. The PR interval is generally full and not infrequently first degree heart block is present. The overall hemodynamic state is improved with a rise in cardiac output by about 30 per cent. The most salutory effects are observed in patients who are afflicted with mitral and aortic valvular insufficiency. Maintenance quinidine therapy has to be continued in an adequate dose of at least 1.2 gm. daily which results in blood level of about 3 mg. per litre. Even with this dose of quinidine, atrial fibrillation will recur within six months in 50 per cent of patients.

Atrial flutter is best treated with cardioversion. It is the easiest disorder to terminate electrically. The arrhythmia generally responds to a single low energy shock of as little as 1 to 5 WS. No serious complications have been encountered.

Supraventricular tachycardias often present complex diagnostic and therapeutic problems.

Frequently, it is difficult to define the mechanism precisely whether it is of atrial or nodal origin. More important is to determine whether digitalis glycosides are responsible for the disordered rhythm. If the arrhythmia is due to digitalis intoxication, electrical shock may provoke lethal disorders of the heart beat. When, however, small energies are employed and lidocaine is used to abolish ventricular ectopic beats, the supraventricular arrhythmias can be safely treated with cardioversion. The success rate, however, is only 70 per cent.

Ventricular tachycardia responds well to antiarrhythmic drugs such as procaine amide and lidocaine and these constitute the preferred therapy. When the arrhythmia, however, is accompanied by significant hypotension, or the patient is in pulmonary edema, or the tachycardia has developed in the wake of acute myocardial infarction and does not yield immediately to a bolus injection of lidocaine, cardioversion should be employed promptly.

Complications

The major complication following cardioversion of chronic atrial fibrillation is systemic or pulmonary embolism. This occurs in one per cent of patients who have not received anticoagulant drugs. If the reversion is elective and the underlying disease is rheumatic valvular, pretreatment with anticoagulants for two to three weeks is indicated. Aside from thromboembolism, atrial and ventricular arrhythmias may complicate the cardioversion procedure. The atrial mechanisms generally are of three types: (1) delayed warm up of the sinus node manifested by sinus bradycardia, nodal rhythm or escape beats—the so-called "somnolent sinus node syndrome," (2) increased atrial automaticity demonstrated by single or multiple atrial premature beats at times associated with brief salvos of tachycardia and (3) "sick sinus node syndrome," a defect in the elaboration or conduction of the sinus impulse characterized by chaotic atrial activity and usually followed by prompt re-establishment of atrial fibrillation.

The ventricular arrhythmias complicating cardioversion are less common but more threatening than the atrial disorders. These are of two types: ventricular fibrillation, which occurs immediately after delivery of the shock and usually is the result of improper synchronization; the second type develops after several beats or within a few minutes and consists of bigeminy or multifocal ventricular ectopic beats which may result in ventricular tachycardia or rarely in ventricular fibrillation. These later arrhythmias are generally associated with excessive digitalis. Lidocaine, in one or more injections of 50 mg. intravenously, is promptly effective.

Conclusion

The method of cardioversion is simple and direct. The physician can observe the entire process of reversion. It does not require a great investment of physician or patient time and is applicable to diverse arrhythmias. Differentiation between ectopic disorders, essential in the use of drugs, ceases to be a critical requisite for effective therapy.

Cardioversion is not accompanied by significant occurrence of serious complications. There is no depression of contractility, conductivity or excitability of the heart—a common sequel after large doses of antiarrhythmic drugs. The method of cardioversion can be readily mastered by the general physician.

There are several good protections against temptation, but the surest is cowardice.

MARK TWAIN

Special Article

Two Old Friends

Charles F. Fisher, M. D.

The Author

- **Charles F. Fisher, M. D., 326 Despard Street, Clarksburg.**

In the history of medicine it is almost impossible to find two articles used together daily all over the world that have maintained such a long association, which persists. I refer to *morphine* and the *hypodermic syringe.*

"Morphine was discovered by Fr. W. Adam Sertürner in this house (see photo) in 1803," reads the inscription on the Memorial Tablet placed on the front of the Apothecary Shop, still in use, in Paderborn, Germany.

Morphine and its salts have been praised, maligned, cursed and, at the same time, the drug has been a great boon to physicians and their patients in distress. In days not long gone by it has had a late partner, atropine sulphate. Morphine at first was administered in many ways, except the oral route which was used for a time and discarded. The drug itself was so extensively used that in 1874 Fiedler published a paper which warned of the "Dangers of the Morphine Habit." Merck, of Darmstadt, Germany, in 1827, began the wholesale manufacture of morphine. Pelletier and Caventou, in 1818, discovered strychnine and, in 1833, atropine was isolated from belladonna by Geiger and Hesse. In 1832, codeine was isolated by Robiquet, and in 1881 Grimaux also obtained codeine from morphine. Tablet triturates were introduced into the practice of medicine by Robert M. Fuller, 1878, in Philadelphia.

For many years morphine and strychnine often were used together in my time as a Resident in the University Hospital, Baltimore, and gradually lost favor as time passed. I sincerely believe that all physicians should read the extensive work of Howard Jones: "The Development of Hypodermic Medication." Jones states that the question at the time of the invention of the hypodermic syringe was "Who really invented it?" The answer given by Jones was that there really was no invention and that the "invention" lay in the adoption of the subcutaneous route for the administration of solutions of drugs.

Wood writes, in 1865, that Charles Hunter calls his method "hypodermic" and replies to Hunter that it does so merely in name. Wood called his method "subcutaneous," borrowing from the Latin, and Hunter's term came from a Greek compound having precisely the same meaning.

Ehemalige Cramersche Hofapotheke in Paderborn Gedenktafel mit der Inschrift: „In diesem Hause entdeckte 1803 Fr. W. Adam Sertürner das Morphium."

Prior to the use of the hypodermic syringe morphine was administered in several ways: Blistering, with massage of the medication into the blister, which was painful. The marks left on

the skin, especially the face, were frequently objected to.

At or about this time there existed four methods of direct medication to the disease:

1. Enepidermic method, in which the remedy was placed directly on the surface of the skin.

2. Iatraleptic, in which the absorbents were stimulated by friction to take up the agent.

3. Endermic, proposed by M. M. Lembert and Lesieur, in which the epidermal obstacle to the entrance of the remedy was overcome by previously removing it.

4. Inoculation (Jenner) used largely for the introduction of "Cowpox and Smallpox".

Bureaud, however, in 1837, reported in *The Lancet* that this method was not successful.

Wood states in his famous article on neuralgia:

1. That medicines are more rapidly absorbed by some tissues than others.

2. That the stomach is by no means the most rapid way of introducing medicines into the system.

3. That the cellular tissues have a greater power of absorption. I believe Charles Hunter held to this last statement also, citing examples of death by bites of poisonous snakes.

Norman Howard Jones wrote "A Critical Study of the Origins and Early Development of Hypodermic Medication." At this time he was Director of the Medical Department of the British Council. I desire to quote the first paragraph of the introduction of his article:

"The effects of the bites of venomous snakes and insects pointed clearly to the possibility of the introduction of drugs through punctures in the skin. In primitive societies, the application for therapeutic purposes of plant and animal products through cutaneous incisions is practiced (Chauvet—1936) and the use of poison arrows may be regarded as a crude precursor of hypodermic and intramuscular medication. Nevertheless it was not until the 19th century that hypodermic medication was initiated, although percutaneous had been employed since ancient times in the form of baths, ointments and cataplasms. The hypodermic was in fact the last of the commonly employed routes to be adopted. The inhalation of medicated vapors, rectal, intra-urethral, intra-uterine and intravenous injections and the injection treatment of hydrocoele all preceded hypodermic medication."

Rynd, in 1854, practiced hypodermic administration of morphine but he did not use a syringe so his procedure was called "hypodermic infusion."

Alexander Wood devised the technique of hypodermic injection in 1853 and introduced it in 1855.

Wood states, and I quote direct from his original article: "Having occasion however about the end of 1853, to endeavor to remove a naevus by injection with a solution of perchloride of iron, I procured one of the little elegant syringes, constructed for this purpose by Mr. Ferguson of Giltspur Street, London. While using this instrument for the naevus, it occurred to me that it might supply the means of bringing some narcotics to bear more directly than I had hitherto been able to accomplish on the affected nerve in neuralgia."

The origin of hypodermic medication was pre-Listerian and many infections occurred, some extensive, and these infections along the nerve supplying the area of pain were often disfiguring." As stated, Charles Hunter advised and practiced distant injection of drugs, based on his theory or idea of absorption.

The syringe used by A. Wood is in the Museum of the Royal College of Surgeons in Edinburgh. One of the greatest benefits resulting from

Figure E.
Alexander Wood, the Father of Hypodermic Injection.

Fig. 1. Lafargue's "Inoculation Medicamenteuse" (Bruns, 1869).

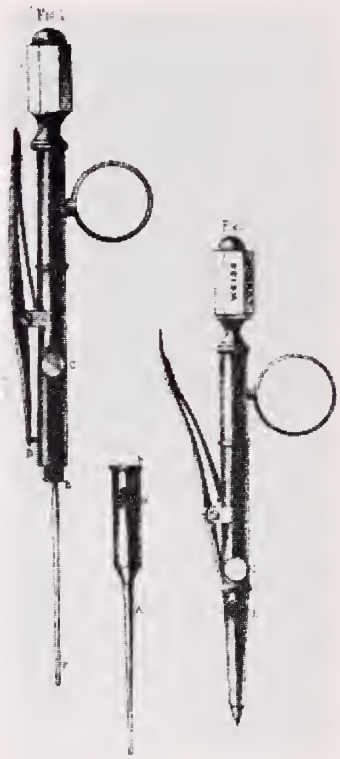

Fig. 2 (left). Von Bruns' Implantation Needle for the Subcutaneous Introduction of Pellets (Bruns, 1869).

Fig. 3 (right). Rynd's Retractible Trocar (Rynd, 1861).

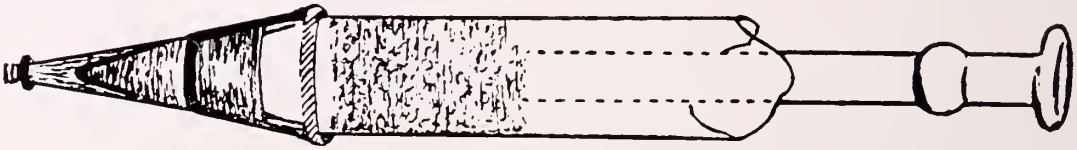

Fig. 4. Syringe used by Alexander Wood (Royal College of Surgeons, Edinburgh. Drawing by Mr. J. H. T. Smith).

the hypodermic medication at that time was that it encouraged physicians to think of precise dosage of single active principles.

The first to use the hypodermic syringe in the United States was Dr. Fordyce Barker of New York City, who received one from Professor Simpson while visiting in Edinburgh and used it here, May, 1856.

Wood, on the occasion of his first hypodermic injection in 1853, used Sherry wine as a solvent for morphine. He felt that Sherry would be less irritating and would smart less than alcohol. In all but Wood's first case, Battley's Sedative Solution was injected.

Wood, in 1858, had improved the syringe in many ways and calibrated it to assure proper dosage. The Luer syringe was the immediate forerunner of the modern instrument. Luer was a Parisian. I have been unable to find the introductory date of the Record syringe, but Schwidetzky, writing in 1944, gives the date as 1906.

"Where there is love of humanity—There is also love for the Art of Medicine."—Hippocrates.

Juries and Malpractice Verdicts

MALPRACTICE suits against physicians and surgeons may originally have been designed—like libel laws for newspapers and like alimony payments for divorcees—to protect the victims.

Today, even more than the libel laws, they have become a kind of punishment for the unwary, a means of stifling resourcefulness . . . and for some unscrupulous lawyers and ex-patients, a way to get something for nothing; like the speed traps that once enriched the coffers of small towns.

In the years between World Wars I and II, it became common practice for petit juries to award heavy damages against railroads, street car and power companies, and automobile drivers, solely because "they are insured," and without regard to the merit of individual cases. None seemed to realize that every responsible American was helping foot the bill for these petty larcenies, through increased insurance rates.

Unilke "big government," we individual Americans have to balance our budgets. When a cost goes up for us, we pass along as much of it as possible to others.

So the American public must come to realize that it generally and ultimately will be paying the cost of damages awarded and the risk involved in insurance policies cancelled by the jury verdicts in malpractice suits.

And the American physician must be increasingly alert to the "speed traps" that could lead to malpractice litigation.—*Journal of the Medical Association of the State of Alabama.*

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A message from . . .

The President

WVU LIAISON COMMITTEE

ELSEWHERE in this issue of *The Journal* is the announcement of the Liaison Committee for the West Virginia University Medical Center. I believe this will prove to be a very important and active Committee this year. I hope that it will serve as a line of communication, in both directions, from the Medical Center and to the physicians in each Society. We believe that this will enable everyone to get at the sources of misunderstanding that might exist much easier.

I think it is important for all to realize that if they cannot serve or attend a meeting they may substitute someone from their Society. In this way we keep up this important line of communication.

I hope also that we can arrange meetings with students from different areas when the Committee meets so that we can keep up the much needed contact between students and physicians.

Also, congratulations to Martha Coyner and her Committee for the excellent Rural Health Conference held at Jackson's Mill on October 2, 1969. The program was well received by the many who attended.

Thanks, Martha.

Maynard P. Pride MD

MAYNARD P. PRIDE, M. D., *President*

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EDITORIALS

We're always looking for ways to make *The Journal* more readable and more interesting—and therefore more welcome in the offices and homes of members of the West Virginia State Medical Association.

LETTERS, LETTERS—LET'S HAVE LETTERS

That's one reason why we sent two editors to Chicago in September to a two-day conference sponsored by the State Medical Journal Advertising Bureau, which handles our national advertising accounts.

Our observers were exposed to some rather profound ideas from experts on the role of the state medical journal and what keeps it going. Some of these notions were far too rich for our blood (e.g., change cover design at least once a year and preferably every month).

One editor from another state came up with what struck us as an excellent idea. Cultivate a lively letters column, he said, and soon each subscriber can hardly wait for the next issue to arrive at his desk.

The letters, he suggested, should not be directed "to the editor" but should amount to a sharing of the authors' opinion with other readers. Of course, *The Journal* has published letters from readers in the past, under such stuffy and lackluster headings as "Correspondence" and "Letters."

Now we are going to try to do what the man said and develop a bright and spirited "letters" section. We'll need a catchy heading, so will someone give us a hand?

Virtually any topic will be fair game for comment and criticism from our readers—one of the scientific articles in the previous issue, rules and regulations of the Welfare Commissioner, Medicare and Medicaid, socialized medicine, heart transplants. You name it, then write us about it.

But, please, let's not get involved in personalities, or at least not too deeply involved.

We'll have to have a few ground rules, so let's start with these:

(1) Contributions should not exceed 250 words in length (editors reserve the right to cut).

(2) All letters submitted for publication must be signed and bear the address of the author.

(3) Editors reserve the right to reject any letter.

Contributions should be sent to: Mr. William H. Lively, Managing Editor, The West Virginia Medical Journal, P. O. Box 1031 Charleston, West Virginia 25324.

So why not drop us a line—RIGHT NOW.

For many months the communications media have, at nearly daily intervals, called attention to the many factors which affect the rising cost of living. One of the three most cited items is the cost of medical care, which with food and clothing costs constitute a definite proportion of the entire inflationary spiral.

UNNECESSARY EVIL

As regards the item of medical care, one factor, the rising costs of professional liability insurance, must be considered a problem which could be amenable to corrective measures by the parties concerned, and it behooves organized medicine to lead in the development and operation of such measures.

Many of our component societies have standing committees invested with the authority and responsibility of joint consideration by the plaintiff, the physician and legal counsel of all threatened legal action for alleged malpractice by the physician or physicians who have rendered services in a given case, but there is no binding obligation on any of the parties concerned to accept the findings and recommendations of parties involved. As a result of this discretionary attitude many suits are instituted with no valid reason therefor, with unnecessary expense and waste of valuable time, and uncalled-for embarrassment to the physician who has been innocent of the alleged errors in judgment and/or treatment, and the results therefrom.

Your correspondent wishes to offer one possible prophylaxis to this painful and unnecessary experience. Inasmuch as a majority of alleged malpractice claims involve the physician in specialty practice it is suggested that (1) every patient presenting himself for treatment shall be required to sign an agreement binding himself to arbitration of any claim for an alleged act of malpractice by a competent board with his acceptance as final the recommendations therefrom; (2) it is suggested that the medical and legal professions, and the malpractice insurance companies make up the arbitration panel whose recommendations as to the validity of any claim or the occurrence of compensable damage shall be binding on all persons.

This will require general acceptance by the men in specialty practice and the legal and insurance professions if justice is to be combined with law in the adjudication of such claims, which, under present circumstances, are largely an unnecessary evil.

THE WVU SCHOOL OF NURSING

The School of Nursing at the Medical Center of West Virginia University was established in 1960. When the Medical Center was planned, the four-year School of Nursing was designed to accommodate approximately 40 entering students. In the first class there were 28 students and 21 of these were graduated in 1964, with the degree of Bachelor of Science in nursing.

During the past few years changes have been made in the nursing curriculum. Presently the first year of the curriculum is given in the College of Arts and Sciences; this is known as the pre-nursing program. During this time, however, courses in nursing orientation also are given. The students enter the School of Nursing proper in the summer session following the pre-nursing program.

The philosophy of the students' training is expressed in the catalog of the University as follows:

"The School prepares students for beginning practice of professional nursing, with an educational background designed to provide a basis for advanced study in nursing and for professional growth and advancement through experience. The School expects that the university student of today will be the leader of tomorrow."

The nursing students are carefully selected by an admissions committee. Students are chosen not only for their physical and mental fitness, but also for personal qualifications appropriate to a professional person. Graduates of diploma schools of nursing also are admitted. In essence, these individuals are expected to spend approximately three years in the School of Nursing, even though some credit is earned by examination.

The School of Nursing has had a phenomenal growth the past few years. Presently, there are 200 students enrolled in the pre-nursing program. In the School of Nursing there are 66 sophomores, 45 juniors and 56 seniors. It is gratifying that so many well-qualified students are interested in the field of nursing.

These young women who are graduated with the Bachelor of Science degree in nursing should indeed become leaders in their chosen profession by virtue of their cultural background, their carefully disciplined curriculum and their high professional ideals. It is to be hoped that most of these graduates will choose to practice their profession in West Virginia. The State is in need of highly trained personnel in all of the health professions.

GENERAL NEWS

22nd Rural Health Conference Attended by 302 Persons

The 22nd Annual Rural Health Conference sponsored by the West Virginia State Medical Association was held at Jackson's Mill on Thursday, October 2, with 302 farm leaders, public health nurses and others in attendance.

Although attendance fell short of the record, many of those who regularly attend the Conference remarked that the program was one of the best ever presented.

The Association sponsors the Conference each year with the full cooperation of the Cooperative Extension Service of West Virginia University, the State Health Department, the West Virginia Home Demonstration Council and the West Virginia Farm Bureau.

Dr. Martha J. Coyner of Harrisville, Chairman of the Association's Rural Health Committee, presided at the one-day Conference. Dr. Stanley H. Martin, President of West Virginia Wesleyan College, gave the invocation, and the remainder of the morning session consisted of talks by Drs. James H. Walker of Charleston and Hu C. Myers of Philippi, and a program on "Who Helps with Health?" which was presented by senior nursing students at Wesleyan College.

Doctor Myers gave a progress report on the Physician's Assistant Program, which is in its second year of operation at Alderson-Broaddus College. Doctor Walker gave an interesting talk on "Medical Quackery." He discussed chiropractic and nostrums that have been marketed in the past for arthritis and various other ailments.

Nursing students participating in the final part of the morning program included the Misses Sharon Bradeen, Candy Hadley and Susie Hoffman. They sketched an imaginary impoverished Appalachian family with typical medical and dental needs and described the public health and social services available to them.

Dr. Maynard P. Pride of Morgantown, President of the State Medical Association, got the afternoon part of the program under way with an address of welcome.

The first speaker was Lauralee Sherwood, D.V.M., Instructor in Physiology and Bio-Physics and Instructor in Public Health and Preventive Medicine at the West Virginia University Medical Center. She gave a very interesting talk on "Prevention of Rabies." She used a poignant motion picture to illustrate her presentation.

Left photo shows three senior nursing students at West Virginia Wesleyan College and two instructors who participated in a discussion of "Who Helps with Health?" during the Rural Health Conference at Jackson's Mill on October 2. In front row are the Misses Susie Hoffman, Candy Hadley and Sharon Bradeen, all students. Behind them are Mrs. Jean Hoff, R. N., Coordinator of Clinical Experiences for the nursing programs at Alderson-Broaddus and West Virginia Wesleyan Colleges; and Miss Hazel Dick, R. N., Instructor in Public Health Nursing at Wesleyan. Gentleman in picture is Dr. Harold Almond of Buckhannon, a member of the State Medical Association's Rural Health Committee. Right photograph shows speakers at the Rural Health Conference's afternoon session. Seated: Lauralee Sherwood, D.V.M., Instructor in Public Health and Preventive Medicine at the West Virginia University Medical Center; Dr. Maynard P. Pride of Morgantown, President of the West Virginia State Medical Association; and Miss Margaret E. Ferguson, Director of Nutrition for the State Health Department. Standing: Col. Robert McCall, Director of Environmental Health Services, State Health Department; State Health Director N. H. Dyer; and Dr. Jack Basman, Director of Maternal and Child Health, State Health Department.

The remainder of the afternoon was devoted to progress reports on several projects of the State Health Department. Dr. N. H. Dyer, State Health Director, led the discussion, and speakers included the following members of his staff:

Miss Margaret E. Ferguson, Director of the Bureau of Nutrition, who spoke on "Nutrition Services in Public Health Programs in West Virginia"; Dr. Jack Basman, Director of the Division of Maternal and Child Health, whose subject was "Expanded Maternal and Child Health Services"; and Col. Robert McCall, Director of Environmental Health Services. Colonel McCall discussed "Environmental Health Problems and Services in Rural Communities."

State Cancer Society Unit Elects Doctor Carey

Dr. James P. Carey of Huntington has been elected President of the West Virginia Division of the American Cancer Society.

The election of Doctor Carey was announced by the State unit's Board of Directors.

Elected Vice President was Dr. Richard A. Currie of the Department of Surgery at the West Virginia University Medical Center in Morgantown.

Other officers include: Mrs. D. N. Thomas of Weirton. Chairman of the Board; Mr. Norris Kantor of Bluefield, Chairman of the Executive Committee; Mr. Max W Saunders of Charleston, Treasurer; and Mrs. P. Walker of Crumpler, Secretary.

Doctor Carey is a graduate of the University of Kansas Medical School. He is a Diplomate of th American Board of Surgery, a Fellow of the American College of Surgeons, and a member of the Cabell County Medical Society and West Virginia State and American Medical Associations.

Dr. Maynard P. Pride of Morgantown (seated left), President of the West Virginia State Medical Association, was guest speaker at a meeting of the Central West Virginia Medical Society, which was held in Buckhannon on October 1. Also pictured are (seated): Dr. Louis W. Groves, Jr., of Richwood, President of the Society, and Dr. Joseph B. Reed of Buckhannon, Secretary-Treasurer. Standing: Dr. Trevor J. Pearman of Glenville; Dr. Rigoberto Ramirez of Buckhannon; Dr. C. R. Davisson of Weston; Dr. Harold D. Almond of Buckhannon; Dr. Joe N. Jarrett of Oak Hill, whose wife, the President of the Woman's Auxiliary to the State Medical Association, was a guest at the meeting; and Dr. R. L. Chamberlain of Buckhannon.

These individuals had parts in the program for the 22nd Annual Rural Health Conference at Jackson's Mill on October 2. Left to right: Dr. Hu C. Myers of Philippi, who spoke on the Physician's Assistant training program at Alderson-Broaddus College; Dr. James H. Walker of Charleston, who discussed "Medical Quackery"; Dr. Martha J. Coyner of Harrisville, who presided at the one-day Conference; and Dr. Stanley H. Martin of Buckhannon, President of West Virginia Wesleyan College who gave the invocation.

WVU Liaison Group Named By Doctor Pride

Formation of a new West Virginia University Liaison Committee of the West Virginia State Medical Association has been announced by Dr. Maynard P. Pride of Morgantown, President of the Association.

To head the Committee, which will have membership from all areas of the State, Doctor Pride selected Dr. E. F. Heiskell, Jr., a Morgantown surgeon.

Doctors Pride, Heiskell and Charles E. Andrews, Provost of Health Sciences at WVU, said the Committee's major role will be to strengthen understanding and open new avenues of cooperation and communication between the WVU Medical Center and practicing physicians throughout the State.

"WVU and its fine medical complex belong to all of West Virginia and not to just one area of the State," Doctor Pride observed. "For that reason, the Committee will consist of at least one member of each of our 27 component medical societies."

Doctor Andrews, himself an active member of the State Medical Association, expressed the hope that a meeting of the Committee can be arranged in Morgantown before year's end.

In addition to Doctor Heiskell, the following physicians were appointed to the Committee by Dr. Pride:

Drs. David E. Wallace of Madison; W. T. Booher, Jr., of Wellsburg; W. L. Neal of Huntington; J. C. Huffman of Buckhannon; Robert R. Pittman of Martinsburg; Joe N. Jarrett of Oak Hill; Robert G. Shirey of Ronceverte; Richard E. Flood of Weirton; and Herman Fischer of Clarksburg.

Drs. Kenneth G. MacDonald and A. Thomas McCoy, both of Charleston; Ray M. Kessel of Logan; G. Thomas Evans of Fairmont; Kenneth J. Allen of Glen Dale; John M. Grubb of Point Pleasant; A. J. Villani of Welch; L. J. Pace of Princeton; Russell A. Salton of Williamson; and Robert J. Fleming of Morgantown.

Drs. Robert S. Robbins of Wheeling; William R. Yeager of Parkersburg; Robert W. Bess, Jr., of Piedmont; Del Roy R. Davis of Kingwood; C. Richard Daniel of Beckley; Buford W. McNeer of Hinton; A. Kyle Bush of Philippi; Terrell Coffield of New Martinsville; and Ross E. Newman of Mullens.

SMA Meeting in Atlanta November 10-13

Several West Virginia physicians will attend and participate in the scienitfic program of the 63rd Annual Meeting of the Southern Medical Association in Atlanta, Georgia, November 10-13.

Several conjoint societies will meet at the same time. They include the American College of Chest Physicians, Southern Chapter; Flying Physicians Association; The Radiological Society of North America; and the Southern Gynecological and Obstetrical Society.

All scientific activities, meetings and exhibits at the SMA meeting are available to physicians who are members in good standing of their local and state medical societies. Those who are not members of SMA will be requested to show membership cards of local and state societies. There is no registration fee.

Dr. Albert C. Esposito of Huntington, Chairman of the Committee on Special Awards, will preside at an awards ceremony on Wednesday, November 12. The Distinguished Service Award, the Original Research Award and scientific exhibit awards will be presented at that time.

Doctor Esposito also is to serve as a discussant for a paper to be presented before the Section on Ophthalmology on Wednesday, November 12, by Dr. Roland J. Sylvester of New Orleans, Louisiana. Doctor Sylvester's subject will be "The Use of Carbochol after Cataract Extraction and after Trauma to the Iris and Ciliary Body."

Among others participating in the scientific program will be Dr. D. Franklin Milam of Morgantown, Professor and Chairman of the Division of Urology at the West Virginia University Medical Center; and Dr. James T. Spencer of Charleston.

Doctor Spencer will present and narrate a film on "Diseases of the Larynx" on Thursday, November 13, at a session of the Section on Otolaryngology.

Doctor Milam will be one of the discussants for a paper entitled "Ileal Conduct Diversion in the Cancer Patient." The paper will be read on Monday, November 10, by Dr. Douglas E. Johnson, before a joint meeting of the sections on Plastic and Reconstructive Surgery, Industrial Medicine and Surgery, Neurology and Psychiatry, Physical Medicine and Rehabilitation, and Urology.

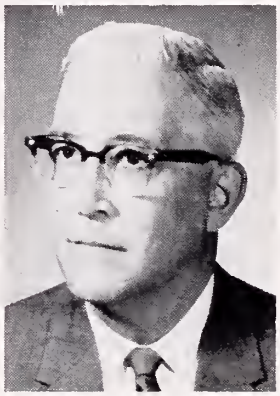
On Wednesday, November 12, Doctor Milam will present a paper and a film at a meeting of the Section on Urology. His paper is entitled "Temporary Gastrostomy as an Adjunct to Ureteroileostomy" and the title of the film is "Internal Urethrotomy of the Female Urethra with New Urethrotomes."

Each of the medical schools in the Southern Medical Association region will be represented by two students. Representatives of the West Virginia University School of Medicine will be Ralph L. Greene, Jr., and Deborah Ann Adkins.

Additional information about the SMA meeting may be obtained by writing to: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama 35205.

W. Va. Heart Association Installs Dr. Richard V. Lynch

Dr. Richard V. Lynch, Jr., of Morgantown, was installed as President of the West Virginia Heart Association during the organization's annual meeting in Parkersburg, September 12-13. He succeeds Dr. Robert J. Marshall, also of Morgantown.



Richard V. Lynch, Jr., M. D.

Forest A. Cornwell, M. D.

Doctor Lynch, a Past President of the West Virginia State Medical Association, is Director of the Out-Patient Department at West Virginia University Hospital.

A native of Clarksburg, Doctor Lynch also has served as President of the West Virginia Tuberculosis and Health Association, the West Virginia Thoracic Society, the West Virginia Diabetes Association and the Potomac Chapter of the American College of Chest Physicians. He received his M.D. degree from the University of Pennsylvania School of Medicine in 1943.

Dr. Forest A. Cornwell, a Beckley pediatrician, was named President Elect of the Heart Association. He will succeed Doctor Lynch in the presidency next year.

Doctor Cornwell was born in Dallas, Texas, and received his M.D. degree from the University of Kansas in 1944. He is President of the Raleigh County Medical Society and also is active in several other medical organizations.

Dr. Thomas J. Tarnay, Assistant Professor of Surgery at the WVU Medical Center, was named Vice President of the Heart Association. Mrs. Ethel Cox and Miss Mary Helen Thompson, both of Charleston, were elected Secretary and Treasurer, respectively.

P. J. Corbitt, Jr., D.D.S., is serving his third year of a three-year term as Chairman of the Board. The new Vice Chairman of the Board is Mr. William Diefenbach of Wheeling.

Heart Symposium in Washington

The 13th Annual Joint Cardiac Symposium, sponsored by the Washington Heart Association and the Heart Association of Northern Virginia, will be held at Marriott Twin Bridges Motor Hotel in Washington, D. C., on April 8, 1970.

AMA Statement on Rubella Vaccine Recommendations

While rubella (German Measles) is generally a mild disease when contracted during childhood, in postpubertal individuals, particularly females, there is considerably greater potential for harm. The illness is often more serious and prolonged and not infrequently has complications such as arthritis, arthralgia, and rarely, encephalitis. In addition, when rubella is present during pregnancy, especially during the first trimester of pregnancy, but also during the second trimester, from 15 per cent to 35 per cent of the infants may be born with what is now known as the congenital rubella syndrome. This includes partial or total loss of hearing or vision, major heart defects, mental retardation or combinations of these defects. In addition, there is a significantly increased proportion of miscarriages and stillbirths. Thus, serious transplacental damage is done by the virus.

The incidence of rubella shows a seasonal increase in the Spring, generally during March, April and May, in the United States, and these seasonal increases, in turn, have superimposed on them major national and international (increases) epidemics occurring at irregular intervals of from approximately six to nine years each. During the last 40 years, there were three exceptionally high pandemic peaks that occurred about 1934 and 1935, 1942, and 1964.

The primary goal of rubella vaccination is the prevention of the congenital rubella syndrome, with secondary goals of preventing rubella in postpubertal patients where disabilities are usually more serious than the relatively mild disease that it causes in young children.

Vaccine Development

In June, 1969, the first rubella vaccine was licensed in the United States. This was an attenuated live virus, manufactured by Merck, Sharp and Dohme. It is made from the HPV-77 strain that has been grown on duck embryo cell culture. This vaccine was tested on over 13,000 susceptible children prior to licensing, with essentially no adverse reactions, although transient arthralgia or arthritis and rash did occasionally occur in older patients.

Smith, Kline and French are currently manufacturing an attenuated live virus rubella vaccine from a different strain (Cendehill). This is grown on rabbit kidney cell culture in Belgium and probably will be licensed in the near future in the United States. There is a similar expectation for an attenuated live virus vaccine that has been grown on dog-kidney cell culture by Phillips-Roxane. In addition, experimental work is progressing at the Wistar Institute in Philadelphia with a still different virus strain (WI-38), which is being grown on human embryo lung cell culture (Diploid cell). Thus, it is very likely that prior to the next seasonal peak, which would be anticipated in spring, 1970, millions of doses of at least three different rubella vaccines will be available for use in the United States.

It is known that, following vaccination, virus particles are shed from the nasopharynx and uterine cervix. However, there have been no reports of cases of rubella as a consequence of the shedding.

Vaccine Administration

The currently licensed vaccine is administered by a single subcutaneous injection of reconstituted lyophilized vaccine. The label and insert instructions should be carefully read and followed. The following precautions are recommended.

Pregnant women must not be given the vaccine because the viremia that follows vaccination and lasts two to six weeks may permit the virus to pass the placental barrier and affect the growing fetus.

If vaccination of a nonpregnant woman in the childbearing age is anticipated, special safeguards should be taken. These might include testing the woman to make sure she is not already immune to rubella* and would include carefully weighing the advantages of vaccine administration against the disadvantages, including the possibility of her becoming pregnant, with the likelihood that the fetus might miscarry or develop the congenital rubella syndrome. If the physician believes that vaccination is desirable, he should prescribe a medically acceptable method for contraception and should explain the potential risk of becoming pregnant to the patient, and, preferably, obtain written, informed consent for the vaccination.

Because of the possibility of placental transfer of maternal immune bodies and the likelihood of these interfering with the development of immunity following vaccination, it is recommended that the vaccine not be administered to children under one year of age. The presence of other virus diseases or any febrile active generalized infection, as well as the use of corticosteroids, irradiation, alkylating agents or antimetabolites or other agents that would weaken the normal defense mechanisms of the individual are contraindications to the use of rubella vaccine. Other contraindications include concurrent use of a different live virus vaccine (eg. measles or poliomyelitis). Administration of the rubella vaccine should then be deferred for at least four to six weeks.

For the Merck, Sharp and Dohme vaccine (Lyovac-Meruvax), epinephrine should be available for immediate use in case of an anaphylactoid reaction. The vaccine (which is grown on duck embryo cell culture) should not be given to individuals who are sensitive to duck or chicken eggs or feathers and, inasmuch as each dose of the reconstituted vaccine contains 25 micrograms of neomycin, individuals sensitive to this drug should not receive vaccine.

General Recommendations

Inasmuch as the vaccine currently available in the United States is still relatively new (about 13,000 susceptible children had been observed for adverse

* The only reliable evidence of immunity is a positive serological test. However, because of the variation among reagents and technical procedures, results of serological tests should be accepted only from laboratories of recognized competency that regularly perform these tests.

reactions prior to licensing), it is possible that unanticipated adverse reactions, particularly in older patients, may occur with the general use of the vaccine. Therefore, it is recommended that any serious adverse reactions be reported promptly to the State Health Department and to the manufacturer who is responsible for reporting it to the Division of Biologic Standards of the National Institutes of Health.

While the frequency of naturally acquired immunity varies considerably with the age of the patient and the incidence and prevalence of the disease in a particular community, the National Communicable disease Center estimates that about 15 per cent of the children under five years of age have become immune through naturally acquired disease, and that for the other age groups the respective natural immunity levels are approximately 35 per cent for the five to nine year olds, 60 per cent for the ten to fourteen year olds, 75 per cent for the fifteen to nineteen year olds, and 85 per cent to 90 per cent for those twenty to thirty-nine years old.

These figures vary from community to community, but may be used as a general guide for the desirability of performing screening tests for susceptibility prior to giving the vaccine. However, each person should be evaluated on an individual basis whenever possible.

For widespread use, in view of the lack of adverse reactions in small children and the fact that about two-thirds of the children under ten would be susceptible, all should receive the vaccine without doing a preliminary serological test for susceptibility. Children in kindergarten and the early grades of elementary school deserve initial priority for vaccination because they are commonly the major source of virus dissemination in the community. A history of rubella illness is usually not reliable enough to exclude children from immunization.

In view of the fact that circumstances will differ in various localities, it is recommended that group programs and public health programs should be launched on the basis of a coordinated plan, developed jointly by state and local public health agencies in cooperation with state and local medical and osteopathic associations.

Pathology Group Elects New Officers

Dr. C. R. Chamberlain of Morgantown was installed as President of the West Virginia Association of Pathologists during a recent meeting.

Doctor Chamberlain succeeds Dr. L. Walter Fix of Martinsburg.

Dr. Grover B. Swoyer of Charleston was elected Vice President and Dr. Dennis S. O'Connor of Huntington was re-elected Secretary-Treasurer.

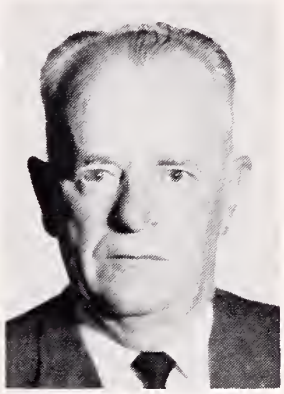
Sports Conference in Denver

The 11th National Conference on the Medical Aspects of Sports will be held in Denver on November 30 in conjunction with the Clinical Convention of the American Medical Association.

AMA Clinical Convention In Denver

The 23rd Annual Clinical Convention of the American Medical Association will be held in Denver, Colorado, November 30 through December 3.

Richard E. Flood, M. D.



Frank J. Holroyd, M. D.

Scientific sessions are planned mornings and afternoons, Monday through Wednesday. They will cover the latest developments in a variety of areas including heart disease, cancer, and pulmonary problems.

Roundtable sessions, previously conducted as breakfast gatherings, will be held at lunchtime at this year's meeting. Topics will include the battered child, problems related to suicide, and human sexuality.

About 25 medical motion pictures will be shown, including several premiere showings, and closed circuit television programming is planned for the major hotels where conventioneers will be staying.

AMA's House of Delegates will meet in the Denver Hilton Hotel. Delegates representing the West Virginia State Medical Association are Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton. Alternate Delegates are Drs. Albert C. Esposito of Huntington and Thomas G. Reed of Charleston.

Other convention sessions will be held in Denver's Convention Center Complex.

Approximately 3,000 physicians are expected to attend the four-day convention. Guests, medical students, registered nurses and other members of allied health professions, and industrial exhibitors are expected to bring the total registration to about 7,000.

The AMA Clinical is the third to be held in Denver. Denver was the host city in 1952 and 1961.

College of Surgeons Inducts Three West Virginians

Three members of the Kanawha Medical Society and the West Virginia State Medical Association were inducted into the American College of Surgeons during ceremonies in San Francisco last month.

They are Drs. Robert L. Leadbetter of Charleston and Ali H. Morad of Ripley, both general surgeons, and Dr. George V. Hamrick of Charleston, an ophthalmologist.

Nurse Education Trust Awards Six Scholarships

Six professional nursing students have been awarded grants for the current academic year by the West Virginia Professional Nursing Education Trust.

The announcement was made by Mr. H. P. Porter, Charleston attorney and Chairman of the Trust Fund, and Cecilia C. Coyne, R.N., of Bridgeport, President of the sponsoring West Virginia Nurses Association.

Trustees renewed a grant to Miss Linda Sue Ellis, who will complete her nursing education at Charleston General Hospital School of Nursing next August.

New grants were awarded to: Mary Constance Coleman of Wheeling, a freshman at Wheeling Hospital School of Nursing; Rebecca Kay Dicken of Fairmont, who will complete her associate degree program at Fairmont State College; Mary Lou Duncan of Bluefield, who will complete her associate degree program at Bluefield State College; Levena May Henderson, of Wellsburg, who is a junior at Ohio Valley General Hospital in Wheeling; and Lois Kay Quesenberry of White Oak, who will complete her associate degree program at the Parkersburg Branch of West Virginia University.

The Trust has made grants totaling more than $22,000 to 44 nursing students over the past 11 years.

Doctor Scherr Presents Paper At Argentine Meeting

Dr. Merle S. Scherr of Charleston was among speakers at the First International Course on Bronchial Asthma, Chronic Bronchitis and Chronic Obstructive Emphysema last month.

The course was conducted at the School of Medicine of Rosario, Argentina, October 6-10.

Doctor Scherr discussed the rehabilitation of the asthmatic patient and participated in seminars on bronchial asthma and other subjects in allergy.

STATEMENT REQUIRED BY THE ACT OF OCTOBER 23, 1962; SECTION 4369, TITLE 39, UNITED STATES CODE SHOWING THE OWNERSHIP, MANAGEMENT AND CIRCULATION OF THE WEST VIRGINIA MEDICAL JOURNAL.

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The known bond holders, mortgages, and other security holders owning or holding one per cent or more of total amount of bonds, mortgages or other securities are: None.

The average number of copies each issue during preceding twelve months are: (A) Total number of copies printed: 2,225; (B 1) Paid circulation through dealers and carriers, street vendors and counter sales: None; (B 2) Paid circulation through mail subscriptions: 1,661; (C) Total paid circulation: 1,661; (D) Free distribution by mail, carrier, or other means: 128; (E) Total distribution: 1,789; (F) Office use, left-over, unaccounted, spoiled after printing: 436; and (G) Total: 2,225.

I certify that the statements made by me above are correct and complete.

(Signed) William H. Lively,
Managing Editor

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Nov. 10-13—Sou. Medical, Atlanta.
Nov. 10-14—Am. Pub. Health Assn., Philadelphia.
Nov. 10-14—Am. Assn. of Pub. Health Phys., Philadelphia.
Nov. 10-14—Am. Col. of Prev. Med., Philadelphia.
Nov. 13-18—Am. Heart Assn., Dallas.
Nov. 30-Dec. 3—AMA Clinical, Denver.

Dec. 5-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

1970

Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 14-18—Am. Acad. of Allergy, New Orleans.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 16-20—Am. Col. of Allergists, Bal Harbour, Fla.
March 20-21—AMA Cong. on Socio-Economics of Health Care, Chicago.
March 30-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 12-18—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-May 2—Am. Ped. Soc., Atlantic City.

May 11-15—Am. Psychiatric Assn., San Francisco.
May 10-14—Am. Urological Assn., Philadelphia.
May 11-15—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.
May 28-30—Am. Oph. Soc., Hot Springs, Va.

June 13-14—Am. Diabetes, Assn., St. Louis.
June 21-25—AMA, Chicago.

July 17-18—Rocky Mtn. Cancer Conf., Denver.

Aug. 20-22—103rd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Sept. 11-19—Am. Soc. of Clin. Path., Atlanta.
Sept. 12-18—Col. of Am. Path., Atlanta.
Sept. 20-24—Am. Acad. of Oph. & Otol., Las Vegas.
Sept. 22-24—Ky. Medical, Louisville.
Sept. 25-Oct. 1—AAGP, San Francisco.

Oct. 4-8—Pa. Medical, Lancaster.
Oct. 5-9—Am. Acad. of Oph. & Otol., Las Vegas.
Oct. 11-14—Virginia Medical, Richmond.
Oct. 12-16—ACS, Chicago.
Oct. 17-21—Am. Soc. of Anes., New York.
Oct. 17-22—Am. Acad. of Ped., San Francisco.
Oct. 25-30—Am. Col of of Chest Phys., Las Vegas.

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Intramural Hematoma of the Duodenum

A. Kyle Bush, M. D.

As a result of the increasing number of non-penetrating wounds of the abdomen during the last decade, a new clinical entity, intramural hematoma of the intestine, producing partial or complete obstruction, has been recognized. The entity was first described by McLachlan[1] in 1838, who described his findings as "a false aneurysmal tumor involving nearly the whole of the duodenum".

Spencer,[2] in 1957, reviewed the literature and found 33 cases of intramural hematoma and reported one additional case. Since then, several cases have been reported. Judd,[3] in 1964, reviewed the literature and reported two cases, bringing the total to 77 cases. Poer and Woliver[4] stated that the duodenum was involved in eight per cent of 1,476 cases of blunt abdominal trauma making it a common site of injury in this type of trauma.

Case Report

J. M. S., a 13-year-old boy, was admitted on September 10, 1967 with nausea, vomiting, and pain in the epigastrium and right hypochondrium. He had been playing football on September 9, 1967, in the "Pop Warner League," and had been kicked in the right upper abdomen with cleats while being tackled. He was removed from the game for a few minutes and then allowed to resume playing. There was little pain, but the following day at 11:00 A.M. he awakened with pain in the upper abdomen, followed by nausea and vomiting of copious amounts of bile-stained fluid. At 5:00 P.M. he was brought to the hospital. The temperature was 98.4° F.; pulse 90, and blood pressure 110/70. Exquisite tenderness and muscle guarding were present in the right upper quadrant, the epigastrium, and extending to the right lower quadrant. There was slight rebound tenderness. No mass was palpable and the abdomen was silent. The hemoglobin was 12.2 Gm. or 82 per cent of normal; M. C. H. C. 31 per cent; hematocrit 39.5 per cent; WBC 16,000 with 78 granulocytes, 34 band cells, 20 lymphocytes, 43 segmented neutrophiles, 2 monocytes, and 1 eosinophile. Blood type Group O, Rh positive C+, D+, E−, C+, E+. The urine revealed a spe-

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Figure 1. Upright film of abdomen showing air in stomach.

cific gravity of 1.010, 0-3 WBC, 3-5 RBC, pH 5.5; sugar negative; albumin negative.

An upright film of the abdomen revealed gas in colon and stomach (Figure 1).

It was felt that a perforated viscus or retroperitoneal hematoma existed. A Levine tube was placed and celiotomy was carried out under Fluothene anesthesia. A right paramedian incision was made. The omentum was found to be contused and a hematoma was noted in the region of the duodenum, also a large hematoma in the transverse mesocolon near its base (Figure 2). A Kocher maneuver was performed on the duodenum and a large hematoma was evacuated from around the duodenum. The serosa of the duodenum was opened in a transverse manner and more clot evacuated (Figure 3). Several very small bleeders were ligated and after being sure there were no perforations the serosa was closed with small interrupted sutures of catgut. The mesocolon was then opened and a large clot evacuated. This was then closed with interrupted sutures of fine chromic. The bowel appeared to be patent; drains were placed and brought out through a stab wound. The abdomen was closed in layers.

The patient was maintained on intravenous fluids for two days while suction was continued. He was then started on liquids and progressed to a soft diet. On the eighth postoperative day, the patient began vomiting and an upright film of the abdomen revealed no evidence of ileus or small bowel obstruction, but the stomach was distended with gas (Figure 4). A Levine tube was reinserted on the ninth postoperative day due to severe vomiting. Gastrograffin was placed in the stomach through the Levine tube revealing some gastric distention and no dye beyond the second portion of the duodenum (Figure 5). On September 21, 1967, re-exploration was carried out through the previous incision. There was no recurrent hematoma; the duodenum was inflamed. A Kocher maneuver was performed but scarring was very dense in the distal portion of the duodenum. The Levine tube could not be

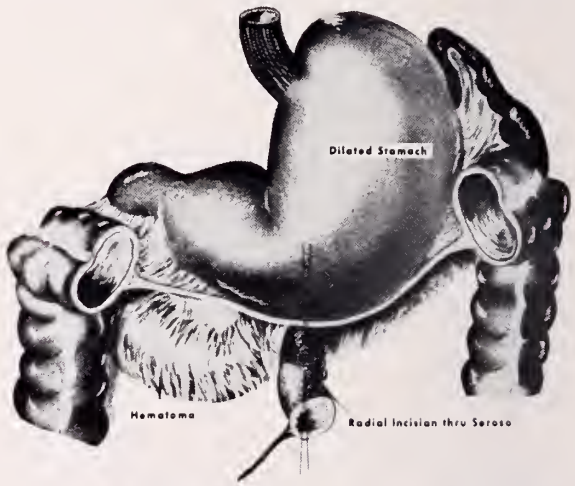

Figure 3. Transverse incision in serosa of second portion of duodenum and evacuation of clot.

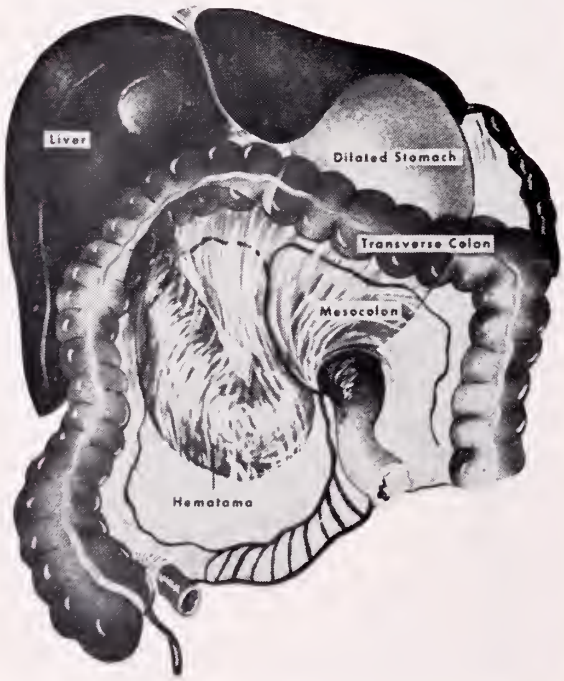

Figure 2. Hematoma of Duodenum and Mesocolon.

Figure 4. Upright film revealing gas in stomach.

passed through this thickened portion of the duodenum. It was decided to do a posterior gastroenterostomy. The posterior portion of the stomach was grasped with Babcock clamps and an opening made in the thickened transverse mesocolon. The mesocolon was sutured to the stomach with 4-0 silk. A short loop of jejunum was brought up to the stomach and a routine anastomosis was performed using an outer layer of interrupted 4-0 silk and an inner layer of 3-0 chromic. After opening the jejunum an obstruction admitting only a small finger could be felt in the third portion of the duodenum. The abdomen was closed in layers.

Intravenous fluids were maintained for 48 hours. Suction was continued for 24 hours. After this the patient was placed on a progressive diet, which was well tolerated. He was discharged on September 30, 1967, in good condition.

He has been followed and postoperative x-rays reveal a functioning gastroenterostomy and opening of the obstruction in the duodenum (Figures 6 and 7).

Discussion

Intramural hematoma of the duodenum usually follows blunt trauma of the abdomen but has been reported in cases of patients with increased bleeding tendencies, and those on anticoagulants.[5] These hematomas may appear in any part of the bowel but the predilection is the duodenum. The reason for this probably is due to their points of fixation and the relative immobility of this segment of the intestine. Griswold[6] believes the injury is inflicted by the force of the blow impinging the viscus against the spinal column with a shearing action.

The hematoma produces obstruction by pressure. When evacuation of the hematoma is incomplete, or drains function improperly, the remaining estravasation of blood in the loose areolar tissue increases in size by virtue of its increased osmolarity due to protein products of hemoglobin disintegration, and ingress of fluids[7] leading to secondary obstruction.

Felson and Levin[8] have described the "coil spring pattern" demonstrated by the barium meal which they consider pathognomonic for intramural hematoma. I have been unwilling to fill the upper gastrointestinal tract with barium when it is apparent that laparotomy will have to be performed. The upright film of the abdomen often will reveal the dilated, gas-filled stomach and duodenum to the point of obstruction as seen in infants with congenital duodenal obstruction.

Summary

A case of intramural hematoma of the duodenum is reported. Usually simple evacuation of the hematoma, with drainage, will suffice as

Figure 5. Gastrografin study with obstruction of duodenum.

Figure 6. Postoperative study with barium revealing functioning post. gastroenterostomy.

treatment; if, however, the duodenum is severely injured, a bypass procedure should be done to avoid a second operation as in the case reported. Careful consideration to bypass will be considered at the time of the original operation if confronted by a similar situation in the future.

Figure 7. Postoperative study with barium revealing functioning post. gastroenterostomy.

Acknowledgment

The author herewith expresses sincere thanks to James Goodman, Medical Artist at the West Virginia University Medical Center, and Richard Crawford, Clinical Photography, The Myers Clinic, for their assistance in the preparation of this paper.

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Wouldn't It Be Wonderful?

WOULDN'T it be wonderful, if parking areas on the outsides of the city would be set apart for commuters, school people, and other city workers, so that they could travel by bus quickly and directly to and from their desired destinations in the city?

Wouldn't it be wonderful if there were more policemen and if these devoted public servants were better paid, better trained, and encouraged to pursue advanced education in police work, sociology, and other areas pertaining to their profession? This would mean more security for all and more efficient, humane and intelligent handling of the citizen with problems.

Wouldn't it be wonderful if the utilities—telephone and electricity—would declare that from now on all wiring, old and new, would be installed underground? Then the several yearly breakdowns in these important services due to storms and snows and winds and explosions would be avoided, thereby decreasing maintenance and upkeep, and bringing some joy to the consumer's pocketbook. Also, who can forget the desolation caused by the destruction of beautiful trees and foliage two or three times a year to accommodate the wiring which has not been changed or improved in appearance in fifty years.

Wouldn't it be wonderful if the dreaming scientists and politicians, who write and talk so much about how great it will be to live in the year 2000 A.D., would come out of their dreams and face up to the realities of 1969?

Wouldn't it be wonderful?—*Rhode Island Medical Journal.*

The Natural Puzzle at the Ileocecal Valve*

Drake Richey, M. D.

The ileocecal valve is one of the few anatomical regions in which the normal as well as the abnormal x-ray configuration presents as a filling defect on the conventional barium enema colon examination. To avoid unnecessary surgery, descriptions of the anatomy and of the anatomical variations of this area have been published. Among these, the enlightening article by Hinkle, in 1952, illustrates a wide range of normal appearances of the ileocecal valve depending on size, shape and thickness of the valve lips, on the degree of prolapse of the ileal mucosa and upon the site of ileal implantation. Others have demonstrated that the valve can change its characteristics either from one examination to another or in fact within the same examination, including competency of the valve. In contrast, malignancies of the gastrointestinal tract are identified by several conventional criteria which include a destroyed mucosal pattern, an overhanging shelf and fixation, although it must be kept in mind that pressure phenomena may change the appearance of a fixed lesion or this may appear to vary from one technique to the next, particularly if two examiners are involved.

Two cases of adenocarcinoma confined to the ileocecal valve were recently encountered which stimulated an interest in the normal variations of the radiographic appearance at the ileocecal area.

Case Reports

Case 1.—A 68-year-old white female was admitted with the chief complaint of weakness and loss of appetite. The history of her present illness dates back approximately six weeks prior to admission, at which time she became aware only of a decrease in her general strength and well being, associated with skin pallor and a decided lack of appetite. Her past history discloses an alleged episode of severe anemia requiring four separate transfusions several years prior to this admission, concerning which she was rather vague. She had one sister who died of complications of diabetes mellitus but there was no other significant family history. The review of systems was basically noncontributory.

Physical examination showed a well developed, well nourished white female in no distress, with skin pallor. There was evidence of cardiomegaly. The abdomen was protuberant but demonstrated no tenderness and no palpable masses or organs. Rectal and pelvic examinations were normal.

The clinical impression was severe anemia associated with gastrointestinal bleeding of undetermined etiology.

Case 2.—An 80-year-old white female was initially examined elsewhere with the chief complaint of swelling of the ankles. The ankle edema was found to be secondary to anemia but the basis for the anemia was not disclosed. She had experienced no bright red rectal bleeding, hemoptysis, hematemesis or black tarry stools. There

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Figure 1. This is the common appearance at the ileocecal valve. Note the small defect in the valvular area with a narrow segment of terminal ileum outlined as it approaches the valve. The appendix can be seen in its usual location.

*Presented before the annual meeting of the West Virginia Chapter, American College of Surgeons, The Greenbrier, White Sulphur Springs, May, 1968.

Figure 2. In the central portion of the compression paddle, a large defect is noted contiguous with a haustral marking on the lateral side of the cecum. There is malrotation but no evidence of reflux into terminal ileum. This patient was explored and a normal ileocecal valve was encountered.

Figure 3. At the onset of the examination, there is a reverse 3 configuration at the ileocecal valve which is markedly different from the normal appearance encountered in Figure 1. The series 3 through 6 were obtained in sequence.

Figure 4. This film now shows a markedly irregular area which mimics an apple-core deformity with overhanging shelves on either end. There is some degree of reflux into terminal ileum.

Figure 5. As the examination progresses, there is a degree of filling of most of the ascending colon and the ominous appearance is beginning to fade.

were weakness and shortness of breath but no chest or abdominal pain. Past history was not remarkable except for left nephrectomy many years ago. There was no history of chronic disease within the family with the exception of malignancy of two siblings. Review of systems was not contributory.

Physical examination revealed a well developed, well nourished white female, alert and cooperative. Her skin was warm and moist, with good tissue turgor. Pallor was not one of the descriptive findings on the physical study. The lung fields were clear and the heart examination showed no evidence of cardiomegaly or audible

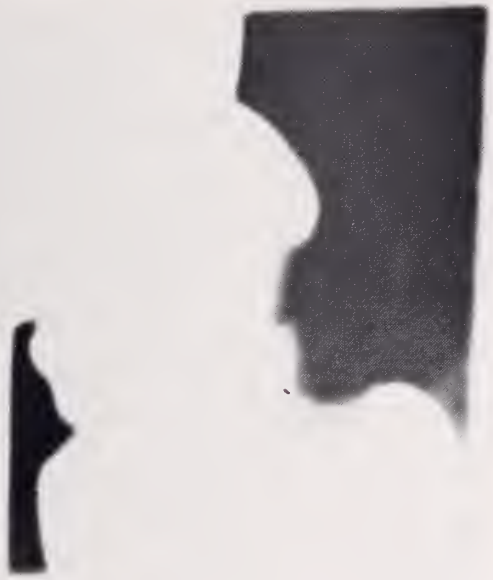

Figure 6. At the end of the examination, the irregular portion of the cecal area has now filled and only a small, smoothly outlined, ileocecal region is noted. This was the first of the illustrated cases and upon exploratory laparotomy a distinct adenocarcinomatous lesion of the ileocecal valve was encountered.

Figure 8. Closer inspection of the area now shows disappearance of the haustral mark and the defect is seen to be in the region of the ileocecal valve, somewhat eccentrically placed. There is no reflux into terminal ileum.

Figure 7. At first glance, the horizontal haustral marking noted at the top of the film appears to be the ileocecal valve while the inferior defect presents as a polypoid lesion.

Figure 9. At the conclusion of the examination, the detect appears larger than on other films. This was felt to be a polypoid lesion at the ileocecal valve but an exploratory procedure showed only a normal variant of the ileocecal valve.

murmur. There was a left nephrectomy scar but there were no palpable organs or masses. The pelvic and rectal examinations were normal.

The clinical impression was neoplastic disease of the proximal colon.

These cases are reported primarily because of their lack of substantial historical or physical findings. The common denominator is anemia of undetermined etiology. Along with other appropriate studies, barium enema examinations were performed and, in each case, a filling defect at the ileocecal valve was noted. The defect was precisely localized to the valve area and the usual appearance of malignancy was absent. There was no constriction, no destroyed mucosal pattern, no over-hanging shelf and no fixation. On both occasions, the valve area appeared more prominent than usual, but repeat studies were performed and presumably because of a change in technique, subtle differences appeared, supporting a diagnosis of an anatomical variant rather than malignancy. Fortunately, evaluation of all studies created such divergence of opinion that exploratory laparotomy was recommended.

Both operations were performed by the same surgeon and grossly abnormal lesions were located precisely at the ileocecal valve. Pathological examinations showed both lesions to be adenocarcinoma.

Discussion

Two defects having the appearance of normal anatomical variants at the ileocecal valve which were disclosed as malignancies precipitated a critical review of the literature concerning this subject. In addition, for a period of one year, careful inspection of the ileocecal region on all barium enema studies was undertaken. This inspection included the use of pressure devices such as the Franklin paddle over the ileocecal valve in order to move the area to help exclude the possibility of fixation. A variety of filling defects created by the ileocecal valve were noted corresponding to the described variants in recent literature, but we have concluded that there is a lack of reliable distinguishing features between these variants and neoplastic disease. We urge that clinically suspected cecal lesions with anemia and a roentgen filling defect which shows even the slightest variation from normal be explored.

Summary

Two cases of adenocarcinoma located at the ileocecal valve are reported and radiographic findings showing a wide variety of normal ileocecal valves are contrasted. The conclusion is drawn that clinically suspected cecal lesions with anemia and x-ray filling defects should be explored.

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Foot in Mouth Disease

The young student nurse was about to begin her first day in a hospital. Remembering the advice of the Head Nurse, she had resolved to encourage patients. Seeing an elderly man who was sitting up in bed she greeted him cheerfully and said, "Well, you don't look like you'll be with us much longer."—*Capsuled Comments.*

Direct Clinical Studies of Ocular Potentials*

Carroll Dunn, B. S., A. J. Magee, M. D., and William S. Randall, B. S.

Clinical studies of electrical potentials usually have been done on the stimulus-response pattern. For instance, the electroretinogram illustrates electrical potentials during a stimulus-response sequence. Our objective has been to study electrical potentials directly in the steady state.

Steady potentials of the eye have been studied directly *in vitro* for a number of years[1, 2] and in animals for even longer.[3, 4] The steady potential of the eye also has been studied indirectly clinically by electrooculography.

We present a clinical method of studying the potentials of the eye, using a direct approach. Our technique can be used also to record stimulus-response type patterns.

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- **A. J. Magee, M. D., Eye Department, St. Francis Hospital, Charleston, West Virginia.**
- **William S. Randall, B. S., Analytical Instrumentation Engineer for Leeds and Northrup Company, Philadelphia.**

Method

The principle involved is the use of calomel half-cell electrodes with a suitable carrier. The present read-out device (Leeds and Northrup Company potentiometer 7401) is a high source impedance, feedback stabilized amplifier which is essentially null balanced in its potential measurement. The electrodes are used in a minimal contact method. The value of the potential is read from the scale of the potentiometer. A pair of two-milliampere fuses are placed in the circuit.[5]

Experiments were done to determine which type of electrode would be most suitable. A saline bath of 0.9 per cent alone or one per cent saline bath with 1/10,000 mercuric chloride added was used. Gauze pads placed on a flat glass and previously saturated with saline 0.9 per cent were employed for contact demonstration. This part of the experiment was done using a recording device (Leeds and Northrup Speedomax Recorder). Steel, gold, platinum and calomel electrodes were evaluated when placed in a bath and using a short duration of contact technique.

The calomel electrodes are of subminiature size (Figure 1). There is a silicone sponge contact tip measuring three mm. in diameter. These electrodes are best kept in a one per cent saline bath with 1—10,000 mercuric chloride added for purposes of antisepsis. A plastic carrier permitting adjustment of distance between the electrodes was developed. It is essential that the electrodes move freely in the vertical meridian to a certain degree.

The technique used (The electrodes were placed by one of the authors and the meter was read by a technician) was a minimal contact method. After taking precautions as for tonometry, especially in regard to antisepsis, the electrodes were placed on the globe in a firm but gentle manner for a count of approximately two seconds, after stabilization. First one eye was done, then the other, at a sitting. The illumination was from 10—25-foot candles. The readings were made directly from the potentiometer; some recordings were made.

Some stimulus-response type tests were run. The potentiometer was fed into a recorder and a bright hand light flashed in the eye with the electrodes in recording position. These tests usually were done after the patient was in a darkened room for 15 minutes. Illumination was just sufficient to place the electrodes accurately.

All experiments from which representative records are shown were repeated with three or more test subjects, and yielded qualitatively the same results.

Results

Study of the electrodes revealed that steel, gold and platinum electrodes were not stable or developed too great an offset (Figure 2). Steel, gold and platinum electrodes showed similar

*Read in part before the Atlantic Section Meeting of the Association for Research in Ophthalmology, Baltimore, Maryland, March 7-8, 1969.

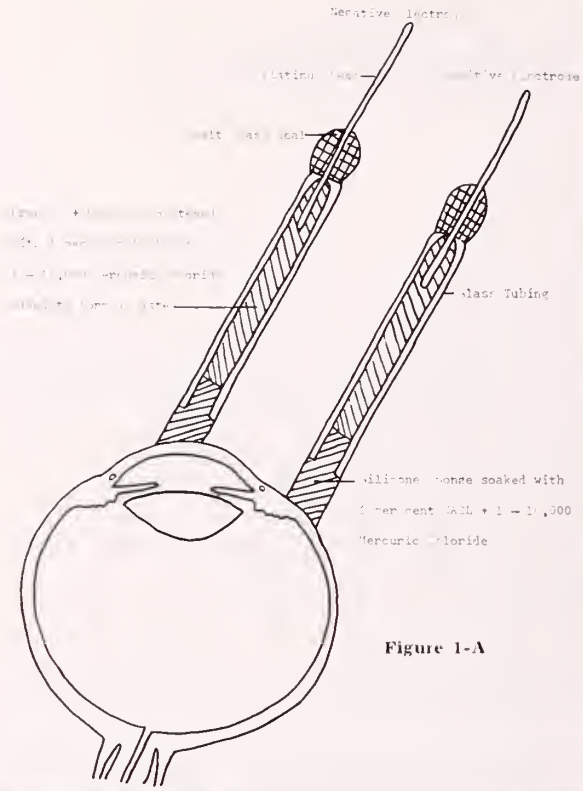

Figure 1-A

Figure 1-C

Figure 1-B

Figure 1-D

Figure 1. (A) Drawing to illustrate placement of electrodes on globe. (B) Similar electrodes in carrier. (C) Similar carrier in covered mount. (D) Bath of one per cent saline, with 1—10,000 mecuric chloride added, in mount.

defects on successive applications to soaked gauze pads. Calomel half-cell electrodes were found to be stable and had minimal offset. Calomel half-cell electrodes varied minimally also on successive applications to soaked gauze pads.

Successive application of electrodes in polar orientation is shown in Figure 3. Here one electrode is on the cornea and the other placed so that its anterior edge is 2 mm. from the limbus. There is a mild rise in potential each time the electrodes are applied, but a general drop occurs on successive applications.

In Figure 4 a routine test is shown. A polar reading is made in the ciliary body area, first on the right eye then the left. Latitudinal placement is then made in the ciliary body area.

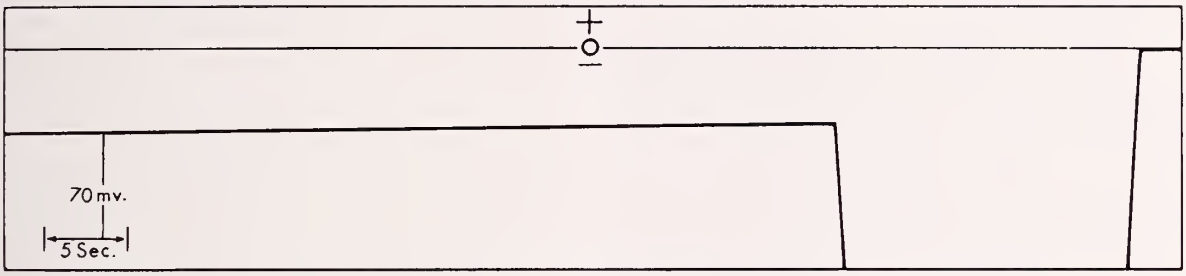

Figure 2-A

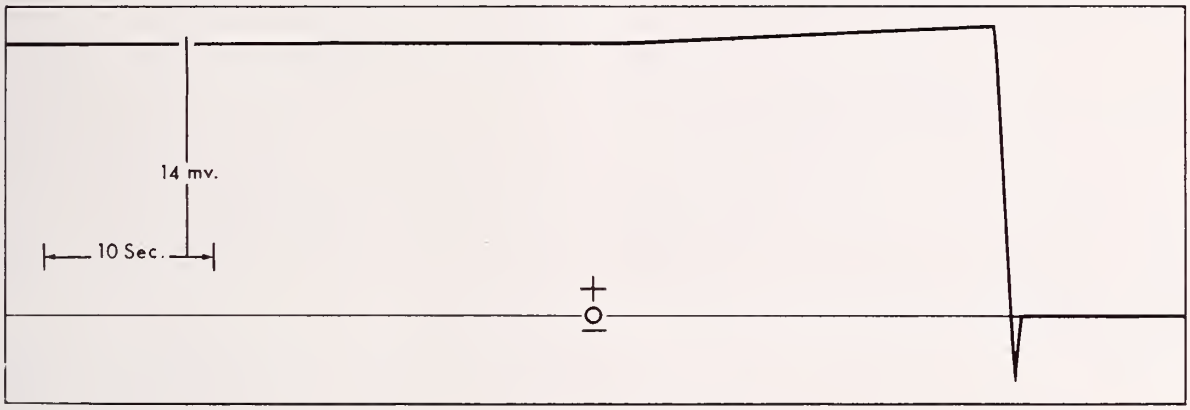

Figure 2-B

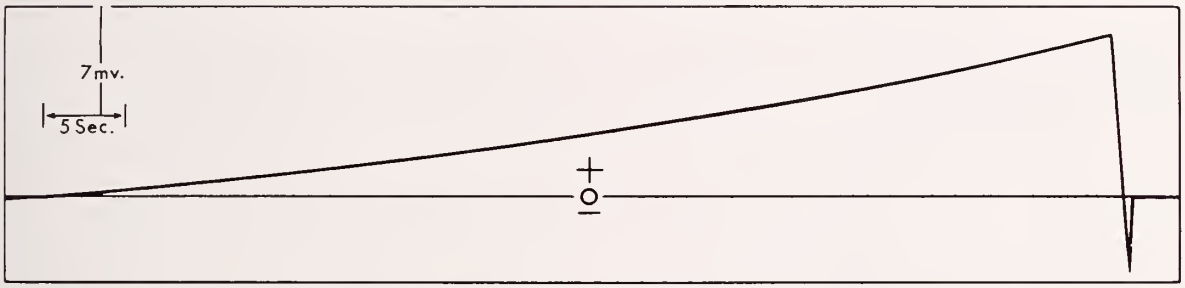

Figure 2-C

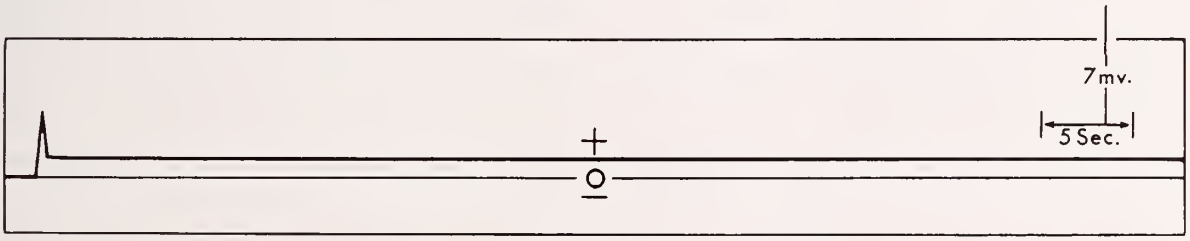

Figure 2-D

Figure 2. Potentials from electrodes placed in 0.9 per cent saline bath alone or in a one per cent saline bath with 1—10,000 mecuric chloride added. (A) Steel, (B) Gold, (C) Platinum, (D) Calomel. (Zero time begins on the reader's right side of the tracing and proceeds to the reader's left.)

Figure 5 shows the result when a light is flashed into the eye with the noncorneal electrode placed approximately over the equator.

There was a stimulus-response pattern which resembled the indirect electroretinogram.

Tracings were then recorded from the orbit of patients who had had a globe removed. No tracings are shown because there is no characteristic response.

We then tabulated the results from 60 control patients. The readings were taken on each eye successively with the noncorneal electrode over the ciliary body area (See Figure 4). The mean value was +12.08 millivolts. At the 95 per cent confidence level potential spread was +10.79-+13.37 millivolts. Furthermore, in normals the value of the potentials always was lower for the first eye recorded, with two exceptions.

Comment

Only calomel electrodes were found suitable. Steel, gold and platinum electrodes were not stable or had too great an offset.

Because of the drop in potential on successive application of the electrodes to the globe (Figure 3) the designation E_o should be used. The E here is short for electromotive force and o indicates approximate time zero.

In recording the potential it is assumed that the first application is the nearest to correct for the technique developed to date. The patient has to be tested again after an indefinite period if the first application is faulty. After application of the electrodes to the globe the corneal microscope reveals definite mechanical trauma of minimal significance.

When the electrodes are placed latitudinally just posterior to the limbus there is a minimal response (Figure 4). There is a significant response when the noncorneal electrode is placed over the ciliary body area compared with the minimal response just mentioned. We feel that this indicates that the organ from which the potentials are derived is a dipole-type structure. The globe has been referred to previously as a dipole-type structure. As a matter of fact, we use this latitudinal placement of the electrodes over the ciliary body area after each test to double check our apparatus, and if we get a reading of less than plus or minus two millivolts we feel that our system is operating correctly. We have encountered this phenomenon in 193 of 210 patients tested. Of the 17 patients in whose cases the minimal response could not be obtained on latitudinal placement the causes were as follows: not apparent, orbit too small, squeezing, photophobia, nystagmus and argyrosis of the conjunctiva.

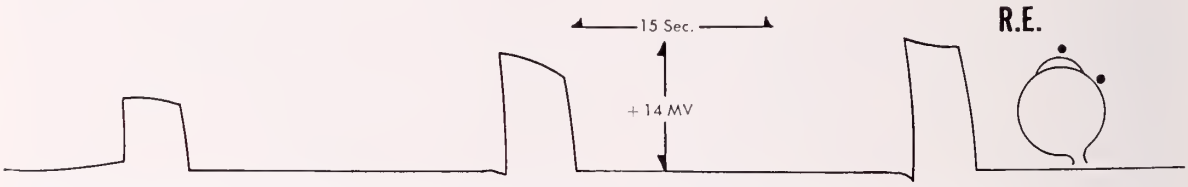

Figure 3. Polar placed electrodes with the noncorneal electrode over the ciliary body area repeated three times. (Zero time begins on the reader's right side of the tracing and proceeds to the reader's left.)

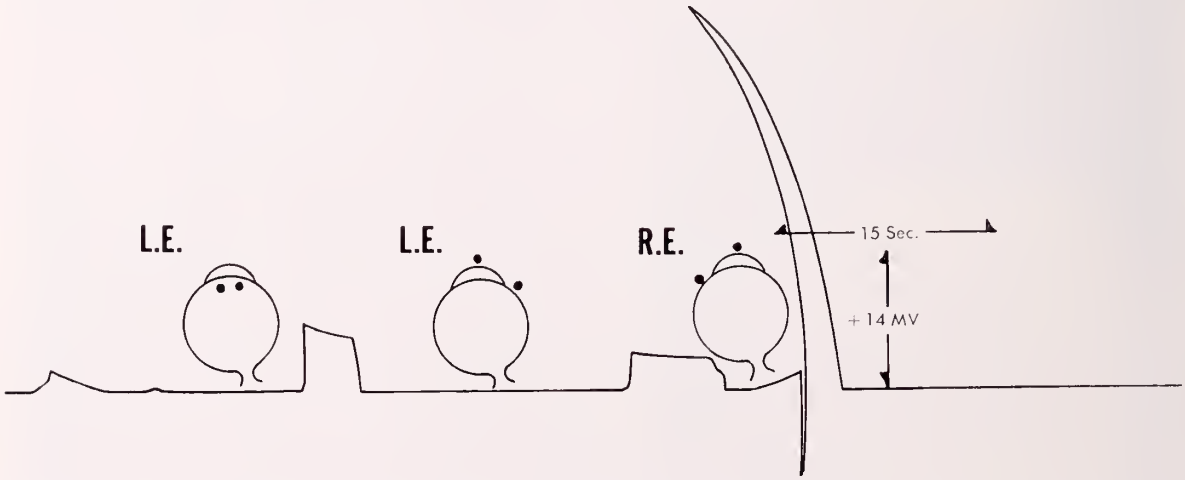

Figure 4. A routine clinical run. Polar placement of electrodes in the ciliary body area first on the right eye, then the left. Latitudinal placement is then made in the ciliary body area on the left eye. (Zero time begins on the reader's right side of the tracing and proceeds to the reader's left.)

The fact that we can obtain a stimulus-response pattern when flashing a light in the eye with the electrodes placed polarwise with the noncorneal electrode over the equatorial area suggests to us that we are recording from the area of the retina (Figure 5).

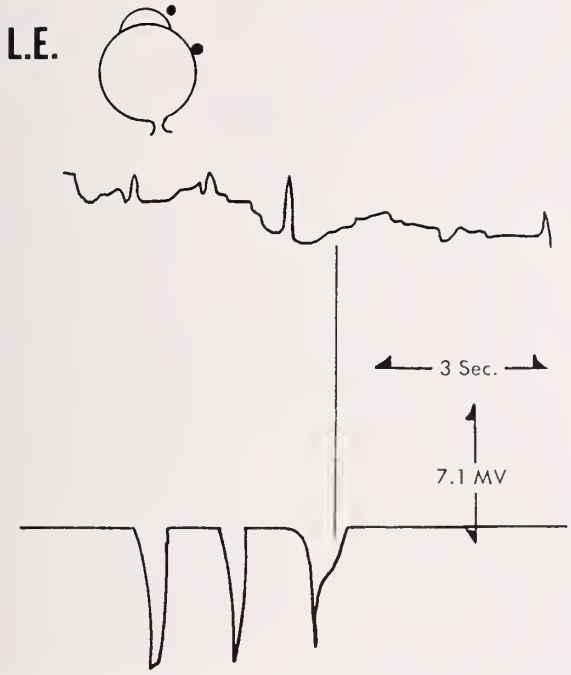

Figure 5. Light flashes with polar placed electrodes; positive over equatorial area. Zero time begins on the reader's right side of the tracing and proceeds to the reader's left. The vertical line after the first time signal is the corrected value. ("Light flash responses" do not conform exactly to the original tracing due to problems involved in the photo engraving process).

When the electrodes were applied polar fashion with the noncorneal electrode in the ciliary body area (Figure 3) a characteristic pattern of tracings was obtained. When the electrodes were placed in a similar fashion in the orbit of a patient whose eye had been enucleated there was no characteristic pattern. This indicates to us that we are recording potentials from the globe with our technique.

At first glance it might appear unreasonable to think that steady potentials could be recorded from the eye with electrodes placed polarwise as described. Here we follow Noell[4] who stressed the idea that placement of the electrode on the cornea is comparable to placing it in the corpus vitrium.

Summary

A method of recording steady potentials from the human eye is presented. We believe these potentials to be truly from the globe, for the following reasons: (1) An approximate zero condition can be obtained by latitudinal placement of electrodes compared with polar placement of electrodes; (2) We can obtain a light stimulus-response type pattern with the noncorneal electrode placed over the retinal area of the globe; and (3) In comparing the potential from an orbit with a normal globe in place, with one in which the eye has been enucleated, a characteristic pattern is obtained with the former, whereas there is a distinct difference in the tracings obtained with the latter.

Lastly, we offer normal static values for the steady potential recorded from the ciliary body area.

Acknowledgment

We herewith express our thanks to D. F. Cole, Ph. D., of London, for his encouragement, review and criticism. We are also grateful to Kenneth Snyder, B. S., Chemical Engineering, for statistical assistance. Mr. Martin Smith of Bussman Manufacturing Company kindly lent the necessary fuses. Leeds and Northrup Company lent the recorders and supplied the calomel. Union Carbide alowed use of their workshop for glass fabrication and donated materials in the construction of the electrodes and carrier.

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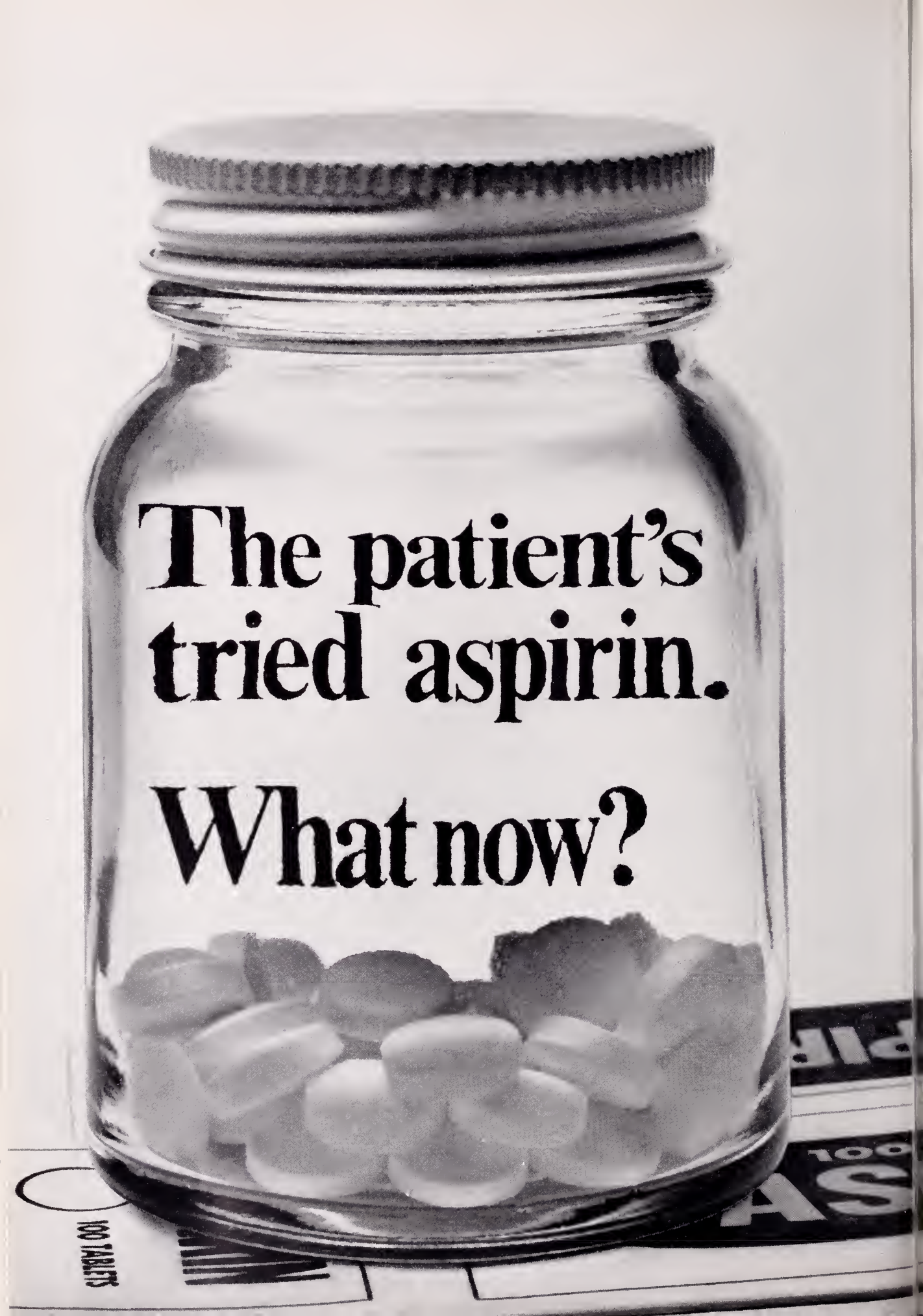
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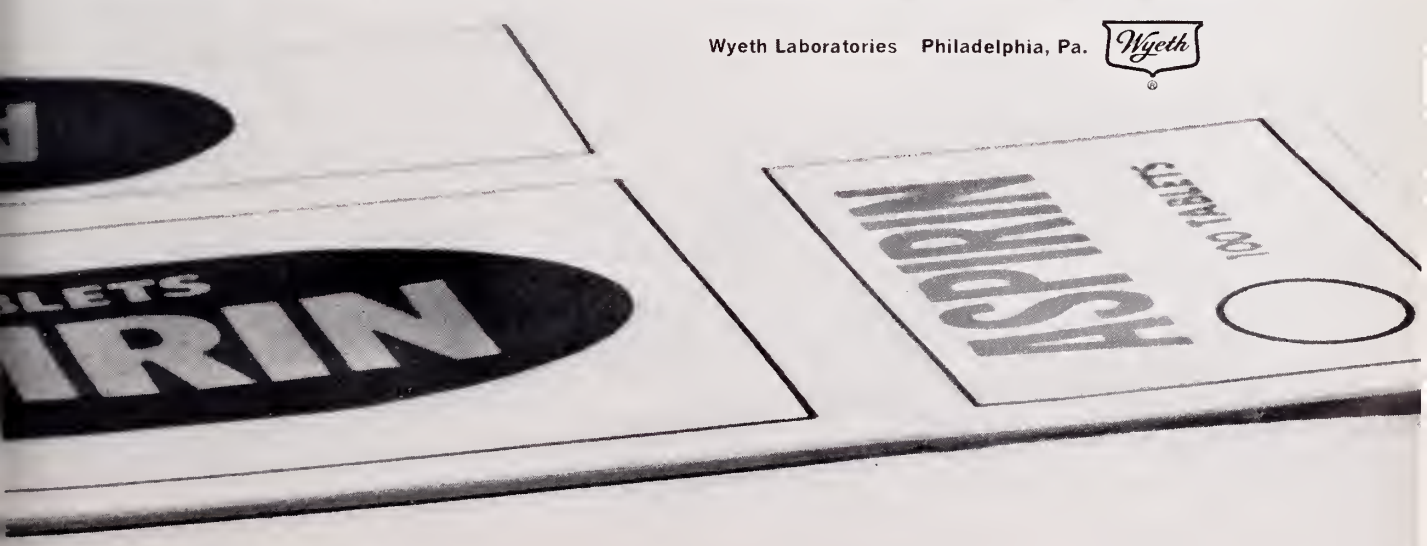

Functional Disorders Resembling Organic Heart Diseases

Edward K. Chung, M. D., and Sang-In Lee, M. D.

As all of us have observed, functional or emotional disorders may produce similar clinical symptomatology as seen in organic heart disease.[1, 10] These interesting, yet all too often baffling patients, present in the offices of internists, cardiologists and psychiatrists. Compounded on the differential between functional and organic disorders, is the occurrence of cardiac patients developing an emotionally induced hyperventilation pattern with all its varied manifestations.[1] Such mixed cases present complex diagnostic and therapeutic problems.

The common clinical entities of such functional disorders are the so-called "cardiac neurosis" (or neurocirculatory asthenia) and "the hyperventilation syndrome".[2, 3]

Cardiac neurosis refers to an ill-defined syndrome of psychogenic or neurogenic origin, often mistaken for organic heart disease.[1, 6] The condition is characterized by dyspnea, precordial pain, palpitation and a general incapacity or inefficiency in adjusting to physical or emotional strain. Various other terms such as "disordered action of the heart," "soldier's heart" and "effort syndrome" have been used by different clinicians to describe this symptom complex.[8]

The underlying cause of this entity appears to be a fundamental egoinsecurity arising from psychological conflicts which begin in infancy and early childhood.[3]

In the majority of cases, a carefully taken history discloses previous serious maladjustments or "nervous breakdowns", long absences from school or work, or an unexplained prolonged illness.[1, 3] As we all know, the heart is the traditional center of emotional expression and there is an early awareness of changes in cardiac activity with the strain of physical and emotional activities.

Symptomatology

We have all experienced transient rapid heart action or palpitation when confronted with sudden emotional change. In extreme situations, the above mentioned symptoms may be markedly exaggerated so that emotionally induced symptoms may arise which resemble true organic heart disease.[10]

The acute anxiety attack often is confused with angina pectoris or coronary thrombosis. Frequently, the acute attack presents with the initial symptoms of the hyperventilation syndrome. By definition, hyperventilation means the occurrence of abnormally prolonged, rapid and deep breathing.[1, 7] Besides an emotional basis, hyperventilation may occur in various chronic lung disorders, or may be produced by the overbreathing of oxygen at high pressures.

The hyperventilation syndrome is a condition in which the patient is subject to repetitive overbreathing, forced respiration, yawning, sensations of air-hunger and a feeling of pain in the thorax.[5, 6] The early subjective sensations are produced by the induced reduction in carbon dioxide concentration in the blood. These sensations include dizziness, a feeling of faintness, profuse perspiration and an unstable gait. The occurrence and severity of the dyspnea are disproportionate to the degree of exercise and to the objective disturbance in ventilation.[2] The involved patients frequently fail to recognize and to report the increase in respiratory rhythm.

Later symptoms of the hyperventilation syndrome include palpitation, complaints of heart pain and band-like feelings about the chest.[1, 4] These symptoms are followed by paresthesias (effect on sensory nerve) in the fingers, toes or perioral region. Patients rarely develop tetany (effect on the motor nerve), an irregular pulse, pallor or loss of consciousness.[2] Hyperventilation and its associated symptoms may go on for several minutes continuously or may recur repeatedly over an extended period. Falling is uncommon, although the patient may fear falling. Symptoms are uninfluenced by postural changes. Asthmatic attacks are frequently precipitated by sudden intense emotional reactions and this is very common among children as a hostile reaction against their parents.[3]

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Pain in the precordium, if carefully evaluated, usually is distinct from that of angina pectoris.[1, 4, 10] It may be a dull, continuous ache or soreness, or it may be sharp and intermittent. The pain usually is localized to the region of the apex of the heart, the nipple, or inframammary area. It usually is unrelated to effort or occurs sometime after a tiring exertion. Unlike the pain of angina pectoris, it does not force the patient to stop activity, nor is it rapidly relieved by rest. Occasionally, there is an associated local precordial tenderness which may be abolished by

Table 1

Various Different Points Between Cardiac and Functional Chest Pain

	CARDIAC	*FUNCTIONAL*
Location	Mostly substernal but anywhere in the chest	Cardiac apex, around the nipple
Area	Diffuse	More localized
Quality	Pressure, tightness	Aching
Radiation	Both shoulder, arms, neck	Left shoulder, back
Duration	Often less than 5 minutes	Often more than 10 minutes or continuous
Tenderness	(-)	Often (+)
By Rest	Often disappear or better	Unchanged or worse
Response to coronary dilator	Good	No effect or doubtful
Response to morphine	Good	Doubtful or unchanged

Table 2

Differential Diagnosis Between Coronary and Functional Chest Pain

	CORONARY	*FUNCTIONAL*
Age	Elderly (age above 45)	Young (age: 20-40)
Sex	Common in male	Common in female
Etiology	Coronary artery disease	Psychologic insecurity and maladjustment.
Precipitating factor	Exercise (eating, working)	Spontaneous or emotional
Hereditary	Family History of CHD and hypertension	Family History of psychoneurotic disorder
Initial symptom	Chest-pain or pressure sensation	Anxiety, dyspnea, hyperventilation.
Feeling of palpitation	(+) Associated with arrhythmia or tachycardia	(+) In the absence of arrhythmia.
Objective signs of heart disease	(+)	(−)
Fever	Maybe (+) (up to 102 F.)	Maybe (+) (rarely exceeds 100. 5 F.)
Fainting	Maybe (+)	Maybe (+): Transient
Shock	Often (+) in acute M. I.	(−)
Heart failure	Often (+)	(−)
Chest film	Often show cardiomegaly or signs of CHF.	Normal
Resting E. K. G.	Abnormal M. I. pattern in M. I.	Normal
E. K. G. during attack	Always abnormal	Almost always normal rarely NAST, T
Arrhythmias	Common	Rare (May show S. T.)
Master's test	(+)	(−)
SGOT, Sed, Rate, WBC	↑	Normal

Key to Tables

(−)	−: Absent	CHF	−: Congestive heart failure
(+)	−: Present	NAST, T	−: Nonspecific abnormality of S-T, T-waves
CHD	−: Coronary heart disease	S. T.	−: Sinus tachycardia
MI	−: Myocardial infarction	↑	−: Elevated

the infiltration of procaine. The pain usually is not relieved by coronary dilators such as nitroglycerine. Chest pain in these cases probably is related to intercostal muscle spasm (see Table 1).

It is very interesting that these patients complain of an uncomfortable feeling of the heart beats in the absence of any cardiac arrhythmias.[1, 2, 4] Often, sinus tachycardia or premature beats may occur, but serious cardiac arrhythmias are very rare. Sinus tachycardia is common, not as a result of effort, but because of the underlying emotional disturbance. Fever of a mild degree is not uncommon but the temperature rarely exceeds 100.5 F.

As a rule, there are no objective signs of organic heart disease but patients may independently experience rheumatic, coronary or other organic heart disease.[9] The electrocardiogram usually is normal, although minor ST, T-wave changes may occur during the attack as a result of the tachycardia itself. The heart is always normal in size except when a concomitant organic process is present.

Differential Diagnosis[1, 10] (See Table 2)

Functional disorders resembling cardiac diseases should be differentiated from rheumatic fever, tuberculosis and hyperthyroidism as well as from coronary heart disease.

If there is any questionable evidence of coronary heart disease, all available tests, including electrocardiogram, serum enzyme studies and sedimentation rate should be used in order to rule out such a possibility. If there is a true fainting episode, the possibility of Adams-Stokes syndrome should certainly be considered, particularly in elderly individuals.

Treatment

The most important aspect of treatment is a firm reassurance as to the absence of any organic heart disease. In general, bed rest often aggravates symptoms and therefore it should be avoided if possible. Needless to say, treatment of underlying psychogenic and neurogenic disorders is essential. Removal of precipitating factors for various functional symptoms is another important aspect of treatment.

Summary

Various aspects of differential points between functional disorders and organic heart diseases are described. It is very important to make correct diagnoses, because two entities are completely different in view of underlying factors, treatment and prognosis. The most important aspect of treatment for functional disorders is firm reassurance as to the absence of organic heart disease. The need for an in-depth history is emphasized.

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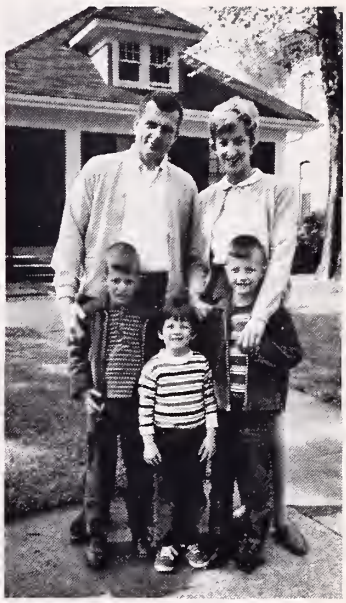

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Unusual Cases of Intestinal Obstruction Due to Food and Drugs

Siroos Gerami, M. D., George W. Easley, M. D., and Catalino B. Mendoza, Jr., M. D.

FOODSTUFFS are recognized as rare causes of intestinal obstruction, but a well established surgical entity. The incidence of this disorder was reported by Handfield-Jones and Parritt,[1] in 1948, as 0.3 per cent of all cases of acute intestinal obstruction. In 875 cases of acute intestinal obstruction reported by Storck, Rothschild and Ochsner[2] (excluding hernias and tumors) foods were responsible for 0.8 per cent of cases. In 375 cases reported by Davies and Lewis,[3] excluding hernias, the incidence of intestinal obstruction due to food was 4 per cent. In 1,282 cases of acute intestinal obstruction reported by Wangensteen,[4] however, not a single case of obstruction was caused by food in the period from 1942 to 1953.

Ward-McQuaid,[5] in 1950, presented a review of the literature in which 178 cases of intestinal obstruction due to 45 different foodstuffs were reported. Since then Norberg,[6, 7] in two papers, described 35 patients with intestinal obstruction due to food, all of whom had had previous gastrectomy for peptic ulcer. Prior to these two papers, six such cases also were reported by Siefert, Baumeister, Fleming, Stalker and Elsving. Other cases have subsequently been reported, probably over 300 in number, with more than 50 foods mentioned as the causative agents.

Intestinal obstruction due to nonabsorbable antacids also has been reported by Havens, Perlman and Brettschmeiger in a total of five cases.[8]

In the period between 1962 and 1967, we had five unusual cases of intestinal obstruction, three of which were caused by food and two by antacids. None of these patients had undergone previous surgery. The obstructing materials in our three cases described as foodstuffs were (1) bran, (2) blackberry seeds, and (3) a combination of cherry, muskmelon and watermelon seeds. Blackberry seeds as a cause of intestinal obstruction have not previously been reported in the literature. Watermelon with seeds has been reported to have produced intestinal obstruction in three cases, but a combination of melon, watermelon and cherry seeds has not been mentioned.

Requests for reprints should be addressed to Doctor Gerami at the West Virginia University School of Medicine, Morgantown 26506.

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Case Reports

Case 1.—A 65-year-old male presented as an emergency case, with a history of intermittent abdominal pain, distention and occasional vomiting of four weeks' duration. During this time he suffered intermittent obstipation and watery diarrhea. Past history included thyroidectomy and laryngectomy for carcinoma two years previously, without evidence of recurrence. The present attack of pain and distention started 12 hours before admission and had grown progressively worse.

Examination revealed an acutely ill, well developed but poorly nourished man. Temperature was 99.4 F., pulse rate 84, blood pressure 110/85. There was severe abdominal distention with generalized tenderness, and decrease in bowel sounds. Rectal examination was negative. There was moderate leucocytosis; serum electrolytes, BUN and blood sugar were normal. X-ray examination revealed elevated diaphragm and marked distention of the small bowel with air fluid levels (Figure 1).

Laparotomy was performed. The terminal ileum and ascending colon were impacted with semi-solid, bulky material. The material in the terminal ileum was milked into the cecum, and a colostomy was done. The impacted mass was broken up sufficiently to be extruded through the colostomy and the material was found to be predominantly muskmelon, watermelon and cherry seeds. The patient made an uneventful recovery following closure of the colostomy.

Case 2.—A 61-year-old male presented with a history of intermittent abdominal pain and periods of abdominal distention. Twenty-four hours prior to admission, the pain became severe, colicky and unremitting, and for the past 12

Figure 1. Upright film of abdomen. Multiple distended loops of small bowel with air fluid levels. (Obstruction caused by combination of watermelon, muskmelon and cherry seeds).

hours he had vomited everything swallowed. On physical examination the patient appeared acutely ill. Vital signs were essentially normal. Physical examination was negative except for marked distention of the abdomen with moderate guarding and tenderness, more severe in the right lower quadrant. Rectal examination was negative. Bowel sounds were decreased but definite tinkles were heard.

X-ray of the abdomen disclosed marked distention of loops of small intestine in the left side of the abdomen (Figure 2).

At laparotomy through a right rectus incision, the terminal ileum and ascending colon were found to be markedly distended with a bulky, semi-solid mass. This was manually broken up in the lumen of the bowel. A cecostomy was performed and a large amount of inspissated food material was evacuated, largely blackberry seeds. Postoperatively, the patient continued evacuating dark, bluish-brown material through the cecostomy. The cecostomy closed spontaneously and the patient made an uneventful recovery.

Case 3.—A 45-year-old white male was admitted with severe, cramp-like abdominal pain, with distention, nausea and vomiting of eight hours' duration. He had been suffering from rheumatic heart disease and auricular fibrillation for several years. There was no history of previous surgery. Physical examination revealed a well developed, well nourished male in acute distress. Temperature was 98 F., irregular pulse rate was 100, blood pressure 125/80. There was a soft systolic murmur at the apex. EKG revealed auricular fibrillation. The abdomen was very distended, with tenderness and muscle guarding generally, more marked over the right lower quadrant. There were high-pitched bowel sounds with tinkles and occasional peristaltic rushes. Laboratory data disclosed mild leucocytosis, normal BUN, blood sugar, urinalysis, and serum electrolytes. Chest x-ray disclosed cardiomegaly. The abdominal x-ray showed multiple dilated loops of small intestine with air fluid levels, interpreted as small intestinal obstruction of unknown cause (Figure 3).

The abdomen was entered through a right rectus incision. The distal ileum was found to be markedly distended above a hard bolus of material found approximately eight inches from the ileocecal valve. The bolus could be moved in the bowel, but could not be broken up manually or milked further into the ileum. Enterostomy was performed and the bolus removed. It was very firm and contained predominantly food bran. On questioning the patient postoperatively, he remembered hastily eating a large breakfast of bran without fluid intake two hours prior to the onset of pain. He made an uneventful recovery.

Case 4.—A 68-year-old white male was admitted with epigastric pain and melena. He had previously been found to have a duodenal ulcer and had been taking large doses of antacids.

Figure 2. Flat plate of abdomen. Markedly dilated small intestine loops in left hemi-abdomen. (Obstructive agent found to be blackberry seeds).

Following admission he was placed on Sippy diet and the antacids continued. The day following admission he suffered a myocardial infarction. The next day he experienced severe, colicky abdominal pain, with distention, nausea and vomiting. The symptoms progressed to alarming severity and, in spite of his recent myocardial infarction, an exploratory laparotomy was performed. The small bowel was packed from a few inches below the ligament of Treitz to the ileocecal valve with a firm, pasty bolus. The proximal jejunum and duodenum were distended with gas. The bolus could not be manually broken up or milked into the colon. Two enterostomy openings were made and the small bowel was emptied of a rather firm, gray, putty-like material. The enterostomy openings were closed and the patient progressed to good recovery, both from his obstruction and myocardial infarction.

Case 5.—A 56-year-old white male, a known case of peptic ulcer of long standing, had been taking antacids and anticholinergic drugs for relief of pain until one month prior to admission, when he developed pain which increased doses of the antacids did not relieve. He came to the hospital for further evaluation. After workup and x-ray studies, a diagnosis of chronic duodenal ulcer was made. The patient was placed on Sippy diet, antacids and probanthine four times daily. After seven days of this therapy he had had no bowel movement, became distended and developed colicky abdominal pain. The Sippy diet and antacids were discontinued and he was placed on nasogastric suction, intravenous fluids, and had numerous enemas without results. The abdominal distention became progressively worse.

Physical examination disclosed high-pitched bowel sounds with tinkles and occasional peristaltic rushes. X-ray disclosed markedly dilated loops of small bowel (Figure 4).

An emergency exploratory laparotomy was performed. The terminal ileum and cecum were packed with a firm bolus of gelatinous, putty-like substance. The mass in the cecum could be manually broken up in the lumen and milked upward readily into the ascending colon. The bolus in the terminal ileum could then be fragmented and milked through the lumen of the ileocecal valve into the cecum. A transverse colostomy was performed and a large amount of gray, sticky, putty-like material was evacuated with complete relief of the obstructive symptoms. The patient went on to normal recovery and was discharged with continuation of his ulcer therapy plus stool softener.

Figure 3. Flat plate of abdomen. Several very dilated loops of small intestine. (Intestinal obstruction caused by bran).

Figure 4. Flat plate of abdomen. Markedly dilated small intestine. (Intestinal obstruction caused by antacid).

Discussion and Comment

It often is difficult to make a diagnosis of intestional obstruction due to food ingestion prior to operation. Ward-McQuaid,[5] in 1950 reviewed the entire literature and gave a report of 178 cases of intestinal obstruction due to foods, listing 45 types of food as obstructing agents. The number reported in 1962 by Norberg[9] had jumped to over 300, with 55 different foods listed as causes. There have been sporadic reports since.

The most common obstructing foods listed by Ward-McQuaid were, in order of frequency, persimmons, peaches, oranges, mushrooms, bran, apples and figs. In more recent reports, orange pulp, celery, tomatoes, kumquats, prune and cherry seeds have been added.[10]

The causative agents are largely variable due to geographic locations. Persimmons in Japan and orange pulp in Europe are the most frequent offenders. Orange pulp is not a frequent cause in the United States where orange juice, rather than whole oranges, is the most popular method of ingestion.

Norberg reported 35 cases of food obstruction following gastrectomy, orange pulp being the most frequent offender. Butler[11] also reported 33 cases of intestinal obstruction due to orange pulp in patients who had previously undergone gastrectomy. They postulate the factors responsible as diminished gastric secretion and loss of pyloric function. It is wondered how many of these patients were on antacids or were taking anticholinergic drugs.

A definite predisposing factor could be previous abdominal surgery with narrowing of the intestinal lumen by adhesions. Inadequate mastication due to poor dentition, eating habits, bolting food, and ingestion of large pieces of indigestible material are listed as causes of intestinal obstruction due to food.

We have reported in this series one case of blackberry seed obstruction, which has not been previously reported. Obstruction due to watermelon and watermelon seeds has been reported in three cases, but a combination of muskmelon, watermelon and cherry seeds has not been previously seen.

Consumption of large doses of nonabsorbable antacid materials is recorded as a rare cause of intestinal obstruction. Five such cases have been previously reported.[8, 12] The obstruction occurs three to five days after ingestion of large amounts of antacid drugs combined with anticholinergics or narcotic medication. When antacid drugs are combined with Sippy diet, as in the cases herein reported, a thick, sticky, putty-like mixture is created. This is further enhanced by the lessened peristalsis caused by the anticholinergic drugs. In cases of bleeding ulcer, the antacid drugs mixed with blood creates a thick, tenacious, meconium-like mixture.

In four of the five cases reported with obstruction due to antacid drugs the patient died. We feel extremely fortunate that the patient in both of our reported cases survived.

Summary

Five unusual cases of intestinal obstruction are reported. Two are due to antacid and one to bran. Blackberry seeds and a combination of watermelon, muskmelon and cherry seeds were obstructive agents in the other two cases, neither of which is cited in previous literature. Symptoms, diagnosis and treatment are discussed.

Acknowledgment

The authors herewith express their appreciation of his review of this manuscript to Bernard Zimmermann, M. D., Professor and Chairman, Department of Surgery, West Virginia University School of Medicine, Morgantown.

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Electrocardiogram of the Month

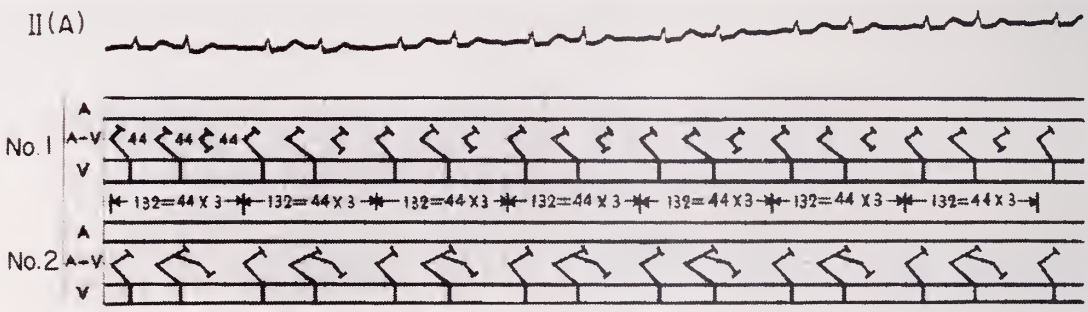
A-V Nodal Bigeminy in the Presence of Atrial Fibrillation

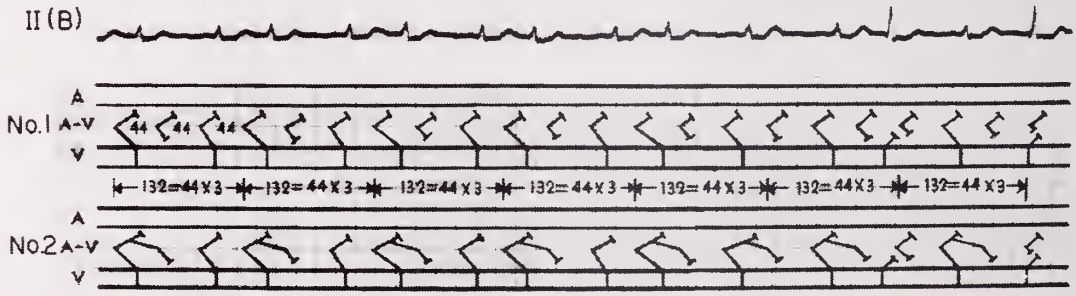
Edward K. Chung, M. D.

Whether atrioventricular nodal beats appear as escape beats or as premature ectopic beats, their electrocardiographic features (other than their effect on the cardiac rhythm and time of onset in the cardiac cycle) are essentially the same.[1, 2] Occasionally, in nodal rhythm with initial excitation of the ventricles (and rarely in association with premature nodal or ventricular ectopic beats), a retrograde P wave may appear "sandwiched" between two closely spaced ventricular beats. The second of these is written prematurely with respect to the usual R-R interval of the prevailing nodal rhythm and is known as a reciprocal beat.[3, 4] This paper presents a case of unusual form of atrioventricular nodal bigeminy which was thought to be due to digitalis intoxication.

The Author

- **Edward K. Chung, M. D., Associate Professor of Medicine and Physician-in-Charge, Electrocardiographic Laboratory, West Virginia University Medical Center, Morgantown.**





Case Report and Comment

M. W., an 88-year-old white male was admitted to the hospital because of acute pulmonary edema and congestive heart failure with myocardial infarction. He expired on the tenth hospital day. The chest roentgenogram showed evidence of left ventricular hypertrophy, pulmonary congestion and pleural effusion. After rapid intravenous digitalization with Cedilanid-D (1.2 mg.), atrial

fibrillation with unusual A-V nodal bigeminy appeared (Figure 1). This tracing is a continuous strip of lead II which represents an unusual form of atrioventricular nodal bigeminy with a basic rhythm of atrial fibrillation. The mechanism or explanation of this rhythm appears to be as follows: (1) Atrial fibrillation and complete A-V dissociation is present throughout the tracing.[1, 2] It is induced by the accelerated activity of a regular A-V nodal pacemaker. The retrograde impulses from this nodal pacemaker cannot enter the atria but keep the region above the pacemaker in a constant state of refractoriness so that none of the rapid atrial impulses reach the nodal pacemaker, and as a consequence, there are no retrograde P waves, and there is a regular irregularity of QRS complexes except for the last portion of lead II (B). One out of three consecutive nodal impulses fails to activate the ventricles following progressive retardation of conduction through the lower part of the A-V junction (Diagram No. 1). The coupling intervals of the short cycles are constant (0.52 seconds) just as are the long cycles (0.80 seconds). Therefore this tracing shows A-V nodal tachycardia with a rate of 138 per minute (cycles length $= \frac{0.52 + 0.80 \text{ second}}{3} = 0.44$ seconds) with complete A-V dissociation and atrial fibrillation associated with exit block with Wenckebach 3:2 conduction (Diagram No. 1).[1, 2] The R-R intervals containing the blocked beats become progressively shorter, with every third beat being blocked thus producing pseudo-bigeminy. It is interesting to note that the interval between the tenth beat and eleventh beat in lead II (B) is exactly two times 0.44 seconds (0.88 second = 0.44 second x 2), and therefore represents 2:1 antegrade block. The twelfth and fourteenth beats of lead II (B) are ectopic beats which probably are from the ventricle (or A-V node with aberrant conduction), and these coupling intervals vary markedly. (2) An alternative mechanism of this bigeminy is that there are reciprocal blocked (rather than nodal) beats occurring every third contraction. This interpretation would make the rhythm A-V nodal tachycardia with complete A-V dissociation and atrial fibrillation. There is also exit block with Wenckebach phenomenon distal to the A-V nodal pacemaker due to blocked reciprocal beats occurring every third contraction.[3, 4]

Summary

A case of unusual atrioventricular nodal bigeminal rhythm is presented, and possible interpretations of the electrocardiograms are explained in detail. One of the more likely of these is nonparoxysmal nodal tachycardia with blocked reciprocal beats occurring every third contraction. The fundamental cause for the development of unusual A-V nodal bigeminy was considered to be digitalis intoxication.

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Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

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Name (please print) _____ *Specialty* _____

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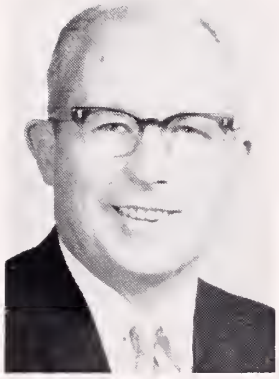

A message from . . .

The President

SEVERAL STEPS FORWARD

THE proposal by the West Virginia University School of Medicine at the last meeting of the newly formed Joint Council of Teaching Hospitals should be hailed as a great step forward in getting the students acquainted with the practicing physicians of the State. They plan to send senior students out into certain approved teaching situations in hospitals which would like to participate in the training of these students. There is no doubt that the contact with the physicians in different areas will be a benefit to both parties and will eventually reap a greater return of physicians to the State. Details of this new program can be found elsewhere in this issue of *The Journal.*

To further this contact we are setting up informal monthly meetings with the student representatives and hope to have more formal programs arranged after the first of the year.

The interest the students have shown in our State Journal has been pleasing. As a result I am happy to announce that, through the action of the Council, copies will be sent to each student. It is recommended that each component society sponsor the subscriptions for the students from their area. This should help bring the local Society and the student closer together. If anyone from the component societies would like to send a copy to students in other schools they need only to notify our State Office.

Maynard P. Pride M.D.

MAYNARD P. PRIDE, M. D., *President*

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The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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EDITORIAL

This month we have received a new medical journal—*Medical Insight*—October, Volume 1, Number 1. The publisher states, "*Medical Insight* was conceived as a journal to be devoted to all aspects of human behavior within the context of the problems faced by the practicing physician . . . Degenerative and malignant disorders, and the ravages of emotional conflict have evolved as the greatest challenges to medicine today."

MEDICAL INSIGHT

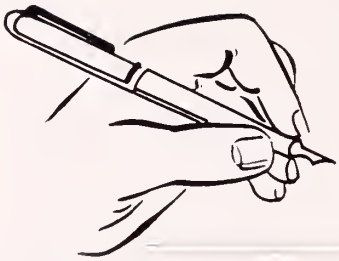
On the masthead we note the name of Dana L. Farnsworth, M. D., Editorial Director of *Medical Insight*. Doctor Farnsworth now holds the joint appointments of Professor of Hygiene and Director of the University Health Services at Harvard University and is a member of the faculty of Arts and Sciences and of the School of Public Health. Associated with Doctor Farnsworth as Co-Editor is Dr. Howard P. Rome, Senior Consultant in Psychiatry at the Mayo Clinic.

Doctor Farnsworth is a native West Virginian and a graduate of West Virginia University. Most of our members will remember Doctor Farnsworth's lecture at our convention in 1967. His paper, "The Drug Problem Among Young People," received nationwide attention and requests for reprints were in the thousands.

The editorial page, "Speaking Out," indicates the broad scope of the magazine. Its purpose is "to disseminate knowledge, to exchange views, to elicit challenge and response, and to further closer relations between psychiatrists, and other health workers and their colleagues in other branches of medicine."

The Journal is pleased to note among the Directors of *Medical Insight* the name of Mildred Mitchell Bateman, M. D., Director of the West Virginia Department of Mental Health, and Member of the Board of Directors of the Menninger Foundation. This is another good reason for the success of the magazine and makes it of additional interest to the medical profession in West Virginia.

If you have not received your copy write the publisher, Insight Publishing Company, 75 Plandome Road, Manhasset, New York, 11030.



Our Readers Speak

A LOT OF 'HOT AIR?'

It has been said that the faculty of the University Medical Center barely even pays lip service to West Virginia medical needs, let alone carrying out anything concrete to cure the problems. Many months ago, a symposium was held at the University attended by the chiefs of residency programs that existed throughout the state. At that time, suggestions were made, recorded, and a separate organization was formed that would make concrete suggestions and circulate the conclusions of that symposium. As it turns out, a prediction that it was all "hot air" and nothing would come by way of the meeting was correct.

After having talked with recent graduates, it is my impression that the entire teaching program should be re-evaluated and re-apportion the time allotted to the various subjects. Many of the men feel that they have been short-changed, timewise, in some departments and wasted time in others.

In order to encourage graduates to return to or stay in West Virginia for the rest of their medical careers as family physicians or specialists, they should be exposed to the facilities available in the state. They could be farmed out in their junior year rather than late in their senior year doing some elective subject. With some planning and cooperation, this could be accomplished in the clinical aspects of their education, especially in the subjects that have a paucity of clinical material in Morgantown, i.e. acute illnesses, both medical and surgical, and obstetrical deliveries.

R. T. Brandfass, M. D.
Wheeling

Editor's Note: *Does the other side demand equal space?*

* * * *

PERSONAL AIR POLLUTER

There has been a growing concern in respect to air pollution. This has been evidenced by public demand and congressional action. In a recent poll, 80 per cent of the respondents felt that additional measures should be taken to minimize the problem. The automobile, the factory, the smokestack and the trash burner are usually pointed out as the culprits. Who considers the Personal Air Polluter (The Cigarette Smoker).

One of the toxic products of the automobile exhaust is carbon monoxide. Exposure for one hour to concentration of this gas of 120 parts per million causes adverse effects upon the blood, resulting in dizziness, headache and fatigue. This concentration is a drop in the bucket to the amount found in cigarette smoke (42,000 ppm). The Personal Polluter survives because most of the time he breathes fresh air. Nevertheless, several Personal Polluters in a poorly ventilated room can cause concentrations of several hundred parts per million. This is exposing not only the Personal Polluter, but also the nonsmokers.

Another important pollutant from the automobile is nitrogen dioxide. This is a highly irritating gas. As much as 3 parts per million have been noted in Los Angeles and levels of 5 parts per million are considered dangerous. Cigarette smoke contains 250 parts per million of nitrogen dioxide.

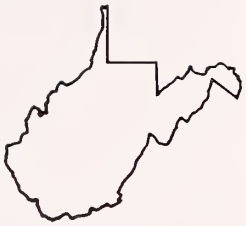
There are many toxic agents in cigarette smoke which are not found in ordinary air pollution. One of these is hydrogen cyanide. It is a highly active agent against respiratory enzymes. Perhaps this could be active in the causation of pulmonary emphysema, common in cigarette smokers. Long time exposure to 10 parts per million is dangerous, yet the concentration in cigarette smoke is 1600 parts per million.

Noxious products such as acrolein, aldehydes, phenols and substance which cause cancer are also found in cigarette smoke. A combination of phenols and cancer causing substances increase the cancer effect. The incidence of lung cancer among smokers is higher in the city than in rural areas.

Of course the principal effect of Personal Air Polluters is on the Polluters themselves. They pay for the habit with chronic diseases and a

(Continued on Page xxii)

GENERAL NEWS



Fall Meeting of the Council In Charleston on Nov. 9

The Fall Meeting of the Council was held at The Daniel Boone Hotel in Charleston on Sunday, November 9, 1969, with the Chairman, Dr. Richard W. Corbitt of Parkersburg, presiding.

Following the invocation by Dr. William E. Gilmore, Doctor Corbitt introduced the following new members of the Council who were elected during the Annual Meeting at The Greenbrier in August: Drs. Joseph B. Reed of Buckhannon, Stephen D. Ward of Wheeling and J. D. H. Wilson of Clarksburg.

Publication Committee Member Reelected

Dr. E. J. Van Liere of Morgantown was reelected a member of the Publication Committee for the term ending December 31, 1976. Doctor Van Liere is Dean Emeritus of the West Virginia University School of Medicine.

Status of Medical Examiner System

Doctor Corbitt, Chairman of the Commission on Postmortem Examinations, presented a detailed report on the status of the Medical Examiner System which is yet to be implemented in the State.

He reported that members of the Commission are making every effort possible to hire a Chief Medical Examiner. He said it is hoped this can be accomplished within the next few months.

He also discussed a series of articles which had been published recently in the Charleston Daily Mail. He was of the opinion that the articles would be of much help in alerting the public to the fact that the Legislature has failed to appropriate sufficient funds to fully implement the Medical Examiner System.

The Council voted unanimously to instruct the Executive Secretary to write a letter to the reporter, Mr. George Moore, commending him for writing such an interesting and informative series of articles.

Joint Council on Teaching Hospitals

Mr. Edward D. Hagan, the Executive Assistant, reported that the third organizational meeting of the Joint Council on Teaching Hospitals was held at the Holiday Inn in Parkersburg on October 23.

He said Dr. David Z. Morgan of Morgantown was elected Chairman of the Joint Council; Mr. Deal Tompkins of Charleston, Vice Chairman; and Mr. William R. Huff of Charleston, Secretary-Treasurer. Dr. George M. Kellas of Wheeling and Mr. Charles Showalter of Charleston were named members of the Executive Committee.

(Additional information concerning the meeting of the Joint Council on Teaching Hospitals may be found elsewhere in this issue of *The Journal*).

Rehabilitation Program

Mr. Thorold S. Funk, Director of the State Division of Vocational Rehabilitation, appeared before the Council to discuss certain problems which he said were vitally important to the health and welfare of handicapped individuals. He was accompanied by several state and regional rehabilitation and Social Security officials.

He cited two of the most critical problems confronting the Division. He reported the Division was experiencing serious difficulty in obtaining medical examinations and reports, particularly in various specialty practices. He attributed this in part to the general shortage of physicians.

He said the second problem is the inability of the Division to fill vacancies for sorely needed physicians on the staff of the Disability Determination Section. He said there was a need for an additional two full-time physicians and a physician who would devote a major part of his time to developing more effective working relationships with the medical community.

Also participating in the discussion were Dr. Buford W. McNeer of Hinton, Chairman of the State Medical Association's Rehabilitation Committee, and Dr. Ralph H. Nestmann of Charleston, a member of the Committee and a former consultant with the Disability Determination Section.

Following the meeting, Doctor McNeer announced that a meeting of the Rehabilitation Committee would be held in Charleston on December 7 for the purpose of attempting to find solutions to the problems now confronting the rehabilitation program in West Virginia. Doctor McNeer also said that Mr. Funk and other members of his staff would be invited to attend.

The following members of the Council were present: Dr. Richard W. Corbitt of Parkersburg, Chairman; Dr. Maynard P. Pride of Morgantown, President; Dr. George R. Callender, Jr., of Charleston, President Elect; Dr. Harry S. Weeks, Jr., of Wheeling, Vice President; Dr. Richard V. Lynch, Jr., of Morgantown, Councilor at Large; Drs. Stephen D. Ward of Wheeling; S. Elizabeth McFetridge of Shepherdstown; A. Kyle Bush of Philippi; J. D. H. Wilson of Clarksburg; Joseph B.

Reed of Buckhannon; William E. Gilmore of Parkersburg; Joseph A. Smith of Dunbar; A. Thomas McCoy of Charleston; Worthy W. McKinney of Beckley; John J. Mahood of Bluefield; and Harold Van Hoose of Man; and Mr. William H. Lively of Charleston, Executive Secretary; and Mr. Edward D. Hagan of Charleston, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Richard E. Flood of Weirton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. Seigle W. Parks of Charleston, a Past President; Mr. James S. Imboden, AMA Field Representative; Dr. Buford W. McNeer of Hinton, Chairman of the Rehabilitation Committee; Dr. Ralph H. Nestmann of Charleston, member of the Rehabilitation Committee; Dr. Mildred M. Bateman, Director of the State Mental Health Department; Mr. Thorold S. Funk, Director of the State Division of Vocational Rehabilitation; Dr. Herbert L. Blumenfeld of Baltimore; Dr. Leo Price of New York; Mr. Anderson J. Allen of Charleston; and Dr. William S. Herold, Chief Medical Consultant of the State Disability Determination Section.

ACP Meeting at Greenbrier November 21-22

Several West Virginia physicians participated in the Ohio, Western Pennsylvania and West Virginia Regional Meeting of the American College of Physicians, which was held at The Greenbrier, November 21-22.

Among guests at the meeting were Dr. Edward C. Rosenow, Jr., of Philadelphia, Executive Director of the ACP, and Dr. Victor W. Logan, an ACP Regent. Doctor Rosenow addressed the group on Friday afternoon, November 21, while Doctor Logan was after-dinner speaker that evening.

Several members of the faculty and staff of the West Virginia University School of Medicine presented papers during the two-day meeting. They are as follows:

"A Recognition of Digitalis Intoxication in the Presence of Atrial Fibrillation"—H. Michael Dean, M. D., and Edward K. Chung, M. D.

"Regional Perfusion and Ventilation of the Lungs" —Anthony Seaton, M. D.

"Black Lung"—N. LeRoy Lapp, M. D.

"Elevated Thyroxine-Binding Globulin in a Family with Goiter"—S. R. Shane, M. D., and J. E. Jones, M. D.

"Fatal Starvation-Induced Hypoglycemia"—Paul C. Davidson, M. D., and Lowell E. Johnson, M. D.

Two Members Are Certified By Neurology Board

Two members of the West Virginia State Medical Association were certified in Neurology in October by the American Board of Psychiatry and Neurology.

They are Drs. Alexander V. Fakadej and James D. Martin, both of Morgantown, and both members of the faculty of the Department of Neurology of the West Virginia University Medical Center.

Compensation Fund Relations Improvement Noted

Officers of the West Virginia State Medical Association have noted a great improvement in relations with the State Workmen's Compensation Fund in the wake of discussions with Commissioner Fred L. Davis, Jr.

The Hon. Fred Davis, Jr., State Workmen's Compensation Commissioner, is flanked by two officers of the West Virginia State Medical Association during a news conference held in his office on October 30. At left is Dr. Kenneth G. MacDonald of Charleston, Treasurer of the Association, and at right is Dr. George R. Callender, Jr., also of Charleston, President Elect of the Association. Mr. Davis announced the appointment of Doctor MacDonald as part-time medical consultant to the Workmen's Compensation Fund and said that fees would be revised.

Mr. Davis held a news conference in his office on October 30, at which time he announced the appointment of Dr. Kenneth G. MacDonald of Charleston, Treasurer of the State Medical Association, as part-time Medical Consultant to the Fund. He said that medical and surgical fees would be revised and a new procedure for payment would be instituted.

"Under the new procedure," the Commissioner said, "medical charges will be reviewed in light of a revised schedule of maximum fees prepared by the Fund and the appropriate professional committee."

He said that as Medical Consultant, Doctor MacDonald would review charges submitted by physicians, and that the review mechanism offered by the county medical societies would be utilized in cases of severe disagreement.

Almost simultaneous with Mr. Davis' news conference, a letter was sent to the membership of the State Medical Association by Dr. George R. Callender, Jr., President Elect of the Association; Dr. Harry S. Weeks, Jr., Vice President; and Dr. Worthy W. McKinney, Chairman of the Compensation Subcommittee.

Mr. Davis "has shown an extreme willingness to work with the members of the West Virginia State Medical Association in making available the best medical care to injured workmen in the State," they said. "At this time we must pledge our continued support to Mr. Davis in this endeavor."

Mr. Davis was a Parkersburg attorney when Governor Moore selected him as Compensation Commissioner earlier this year. The young Commissioner has demonstrated a cooperative spirit and has consulted with officials of the State Medical Association from time to time during the past year.

Dr. Albert C. Esposito Named SMA President Elect

Dr. Albert C. Esposito of Huntington was named President Elect of the Southern Medical Association during the SMA's 63rd Annual Meeting in Atlanta, Georgia, on November 12.

Albert C. Esposito, M. D.
President Elect, Southern Medical Association

Doctor Esposito, a Past President of the West Virginia State Medical Association, moves up from the office of First Vice President in the medical organization in which he has been active for many years. He will be installed as President of the 16-state group during the 64th Annual Meeting in Dallas, Texas, next November 16-19.

At that time he will succeed Dr. J. Leonard Goldner of Durham, North Carolina.

Southern Medical has several thousand members in the District of Columbia and the states of Georgia, Virginia, Alabama, Arkansas, Florida, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and West Virginia.

A native of Pittsburgh, Doctor Esposito received a B.S. degree from the University of Pittsburgh and received his M.D. degree in 1938 from the Loyola University School of Medicine in Chicago.

A Diplomate of the American Board of Ophthalmology, Doctor Esposito has lectured at medical meetings in this country and abroad. His many professional associations include fellowship in the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology.

He was a member of the Council of the State Medical Association, 1959-63. He then served as Vice President, President Elect and President. He held the latter office in 1964-65.

During the Annual Meeting of the State Medical Association last August, he was named Alternate Delegate to the American Medical Association.

Doctor Esposito has been a member of the State Board of Examiners for Practical Nurses. During World War II, he was a Major in the Medical Corps of the U. S. Army. Since the end of the war he has been engaged in the private practice of ophthalmology in Huntington.

Drs. Basman and Baldock Elected Members of AAP Section

Drs. Jack Basman and Harry E. Baldock of Charleston were recently elected to membership in the American Academy of Pediatric's Section on Community Pediatrics. The announcement was made following a recent meeting of the Academy's Executive Board.

Doctor Basman joined the State Health Department last spring as Director of the Maternal and Child Health Division after being in the private practice of pediatrics for more than 30 years. Doctor Baldock serves as Pediatric Consultant to the same Division.

Membership of the Section on Community Pediatrics consists of Fellows of the Academy in full-time salaried positions administering child health services under public health auspices; salaried consultants to such organized programs; and investigators and teachers concerned with organized systems of care.

Dr. Robert L. Smith Named To UMW Post

Dr. Robert L. Smith of Morgantown has been appointed Morgantown Area Medical Administrator for the United Mine Workers of America Welfare and Retirement Fund.

Doctor Smith has been serving as Assistant Medical Administrator under Dr. Hubert T. Marshall, who retired. Doctor Marshall is continuing his association with the Fund as an advisor.

Doctor Smith is a native of Keithsburg, Illinois, and received his M. D. degree from the College of Medicine in Chicago in 1944. He served in the U. S. Public Health Service for several years.

Medical-Legal Seminar in Morgantown

The first annual Medical-Legal Seminar was held in Morgantown, November 14-15, under the sponsorship of the West Virginia Trial Lawyers Association and the School of Medicine and College of Law of West Virginia University.

Among the speakers were Dr. Clark K. Sleeth, Dean of the School of Medicine; Dr. James H. Wiley of Morgantown; and Dr. Richard W. Corbitt of Parkersburg, Immediate Past President of the State Medical Association.

New Association Members

Dr. A. V. Fakadej, WVU Medical Center, Morgantown (Monongalia). Doctor Fakadej, a native of North Versailles Township, Pennsylvania, was graduated from the College of William and Mary and received his M. D. degree in 1961 from the University of Virginia School of Medicine. He interned and served a residency at University of Virginia Hospital. He served as a Captain in the Medical Corps of the United States Air Force, 1966-67, and his specialty is pediatric neurology.

* * * *

Dr. Jose G. Alfonso, Appalachian Regional Hospital, Beckley (Raleigh). A native of Santa Clara, Cuba, Doctor Alfonso received his M. D. degree in 1946 from the University of Havana. He interned at Children's Hospital of Havana and served residencies at that Hospital, Kanawha Valley Memorial Hospital in Charleston and Appalachian Regional Hospital. His specialty is pediatrics.

* * * *

Dr. Esteban Friera, Hampshire Memorial Hospital, Romney (Potomac Valley). Doctor Friera, a native of the Philippines, received his M. D. degree in 1957 from Far Eastern University of Manila. He interned at Weirton General Hospital and served a residency at South Baltimore General Hospital, Baltimore, Maryland. His specialty is general surgery.

* * * *

Dr. Alfred D. Ghaphery, 601 National Road, Wheeling (Ohio). Doctor Ghaphery, a native of Wheeling, was graduated from Notre Dame University and received his M. D. degree in 1959 from the University of Pittsburgh School of Medicine. He interned at Cook County Hospital in Chicago and served residencies at the WVU Hospital and the VA Hospital in Pittsburgh. He served as a Captain in the Medical Corps of the United States Army, 1965-67, and his specialty is surgery.

* * * *

Dr. Gary G. Gilbert, 418 11th Street, Huntington (Cabell). Doctor Gilbert, a native of Huntington, was graduated from Marshall University and received his M. D. degree in 1963 from the West Virginia University School of Medicine. He interned at Riverside Hospital in Newport News, Virginia, and served residencies at Women's Hospital, Johns Hopkins Hospital and the Greater Baltimore Medical Center. He served with the United States Navy, 1952-56, and his specialty is obstetrics and gynecology.

* * * *

Dr. Segundo Carlos Iturriaga, Laird Memorial Hospital, Montgomery (Fayette). Doctor Iturriaga, a native of Cuba, received his M. D. degree in 1946 from the University of Havana School of Medicine. He had additional training at Laird Memorial Hospital from 1961 to 1965. He is engaged in general practice.

* * * *

Dr. John F. Kelley, WVU Medical Center, Morgantown (Monongalia). Doctor Kelley, a native of Gay, Jackson County, was graduated from Marietta College and received his M. D. degree in 1958 from McGill University in Montreal, Canada. He interned at the Medical College of Virginia and served residencies at the Columbus Psychiatric Institute and Hospital, Ohio State University Medical Center and Worchester Youth Guidance Center, Worcester, Massachusetts. He served as a Lieutenant Commander in the Medical Corps of the United States Navy, 1962-64, and his specialty is child psychiatry.

* * * *

Dr. N. Leroy Lapp, WVU Medical Center, Morgantown (Monongalia). Doctor Lapp, a native of Perkasie, Pennsylvania, was graduated from Eastern Mennonite College and received his M. D. degree in 1961 from Temple University School of Medicine. He interned at St. Luke's Hospital in Bethlehem, Pennsylvania, and served residencies at that hospital and at the Mayo Graduate School in Rochester, Minnesota. His specialty is internal medicine.

* * * *

Dr. James O. Merritt, 107 Rider Drive, Beckley (Raleigh). Doctor Merritt, a native of Ada, Minnesota, was graduated from Drake University and received his M. D. degree in 1952 from the University of Iowa School of Medicine. He interned at Illinois Masonic Hospital and served residencies at the Rollman Psychiatric Institute and Dorothea Dix Hospital. He served as a Sergeant in the United States Air Force and his specialty is psychiatry.

* * * *

Dr. John P. Sheils, Cabell-Huntington Hospital, Huntington (Cabell). Doctor Sheils, a native of Huntington, was graduated from Marshall University and received his M. D. degree in 1960 from the Medical College of Virginia. He interned at Roanoke Memorial Hospital and served a residency at Cabell-Huntington Hospital. He served as a Captain in the Medical Corps of the United States Army, and his specialty is pathology.

* * * *

Dr. Gary M. Tolley, 1st Huntington National Bank Building, Huntington (Cabell). Doctor Tolley, a native of Lesage, Cabell County, was graduated from Marshall University, attended the two-year WVU School of Medicine and received his M. D. degree in 1961 from the Medical College of Virginia. He interned at Charleston Memorial Hospital and served a residency at Indiana University Medical Center. He served as a Lieutenant in the Medical Corps of the United States Navy, 1962-65, and his specialty is radiology.

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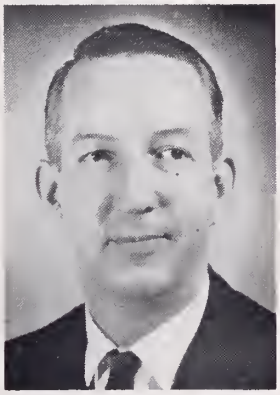
Dr. Alfred J. Den, Kings Daughters Hospital, Martinsburg (Eastern Panhandle). Doctor Den, a native of Santa Barbara, California, was graduated from the University of Santa Clara and received his M. D. degree in 1939 from Georgetown University School of Medicine. He interned at Garfield Memorial Hospital and served a residency at the Radiological Clinics of Grover, Christie and Merritt in Washington, D. C. He served as a Major in the Medical Corps of the United States Army, 1943-46, and his specialty is radiology.

Hospital Council Organizes, Elects Doctor Morgan

The Joint Council on Teaching Hospitals elected permanent officers and accepted its first project during a meeting in Parkersburg on October 23.

Dr. David Z. Morgan of Morgantown, who had been serving as Chairman Pro Tempore since the Council's first meeting last spring, was elected the first permanent Chairman. One of the West Virginia State Medical Association's three representatives on the Council, Doctor Morgan is Associate Professor of Medicine and Assistant Dean of the West Virginia University School of Medicine.



David Z. Morgan, M. D.

Deal H. Tompkins

Named Vice Chairman was Mr. Deal H. Tompkins of Charleston, President of the Board of Trustees at Charleston General Hospital. Mr. William R. Huff of Charleston, Executive Vice President of the West Virginia Hospital Association, was named Secretary-Treasurer.

Doctor Morgan and Messrs. Huff and Tompkins were elected to terms which expire on July 1, 1971. They and Dr. George M. Kellas of Wheeling Hospital and Mr. Charles L. Showalter, Administrator of Charleston Memorial Hospital, will comprise the Council's Executive Committee.

The terms of Mr. Showalter and Doctor Kellas will extend to next July 1.

Dr. Charles E. Andrews, Provost of Health Sciences at WVU, and Dr. W. W. Spradlin, Professor and Chairman of the Department of Psychiatry at WVU, asked the Council to consider, as its first project, overseeing a new program for fourth-year medical students.

After considerable discussion, the Council enthusiastically accepted the proposal.

The following description of the project was submitted by Doctor Spradlin:

Criteria for Extramural Selective Experience

"Beginning July 1, 1970, fourth-year students will have part of their curriculum devoted to a selective course of study. This time may be spent in West Virginia hospitals which are accredited and full members of the West Virginia Teaching Hospital Council and other university hospitals.

"To provide an extramural selective program, the teaching hospital administrator and the extramural program director must submit a description of the selective program or programs for approval by the Dean, the equivalent intramural program director and/or student advisor.

"The description should include:

"1. A description of the clinical, teaching or research experience.

"2. Guarantee of adequate and specified supervision by licensed clinicians.

"3. Statement confirming coverage of student by health and malpractice liability insurance under the auspices of the participating hospital.

"4. Arrangements for room, board and/or reasonable coverage of student living expenses while participating in the program.

"External selective programs will be visited by West Virginia University representatives from equivalent intramural programs and extramural program directors will submit to the Dean's office reports and grades on students rotating through the program.

"Combined vacation (non-credit) and selective experience in teaching hospitals will be regulated by the same criteria.

"Description of selective experiences including above criteria should be signed by extramural program director and the administrator of the hospital.

"Consent for extramural selective activity by any student will be given after mutual agreement of extramural and intramural program directors, the Dean and the student's faculty advisor.

"Description of extramural selective experience will be filed in the Dean's office and copies will be circulated to students, their advisors and intramural program directors."

Twenty-two members and guests attended the meeting. Both the West Virginia State Medical Association and the West Virginia Hospital Association were represented as were the following hospitals:

University Hospital, Morgantown; Ohio Valley General Hospital and Wheeling Hospital, Wheeling; Charleston General Hospital and Charleston Memorial Hospital, Charleston; Herbert J. Thomas Hospital, South Charleston; Chesapeake and Ohio and Veterans Administration, Huntington; Broaddus Hospital, Philippi; and Veterans Administration Hospital, Clarksburg.

Family Practice Board Announces First Examination

The American Board of Family Practice has announced that it will give its first examination for certification at various cities in the United States next February 28-March 1.

Information regarding the examination and eligibility for the examination can be obtained by writing to: Dr. Nicholas J. Pisacano, Secretary, American Board of Family Practice, University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

Report on Annual Conference Of Auxiliary Officers

The 26th Annual Conference of National Officers and Chairmen, State Presidents and Presidents Elect of the Woman's Auxiliary to the American Medical Association was held in Chicago, October 5-8. The four-day leadership Conference featured programs dealing with community and international health, home-centered health care, mental health, and safety-disaster preparedness.

Attending from West Virginia were Mrs. Wilson P. Smith of Huntington, Eastern Regional AMA-ERF Chairman; Mrs. Joe N. Jarrett of Oak Hill, President of the Woman's Auxiliary to the West Virginia State Medical Association; and Mrs. Robert J. Tchou, of Williamson, President Elect of the State Auxiliary.

Mrs. John M. Chenault of Decatur, Alabama, President of the Woman's Auxiliary to the AMA, opened the October 6 session, introducing Dr. Gerald D. Dorman, President of the American Medical Association, who stressed the importance of furnishing factual information to the country's youth.

Mrs. R. C. L. Robertson of Houston, Texas, National President Elect and Conference Presiding Officer, introduced Dr. Howard A. Schneider, Department Head of the Experimental Medical Ecology Department of the Institute for Biomedical Research, whose address entitled "What Makes a Scientist Tick" gave a clearer insight into the scientific future.

Included on Monday's agenda were addresses and greetings from WASAMA President Mrs. Carl Welch and President Elect Mrs. G. Edward Kappler. A colorful slide presentation, "The Health Teams," with taped narration combined with staff informational talk on Health Careers, was shown.

Other prominent speakers included Dr. Ernest B. Howard, Executive Vice President of the AMA, who spoke of general health care and stated that our nation's 200-plus million population grows by 2 million a year—and medical manpower needs are increasing at an extremely rapid rate, requiring stimulating action programs to increase workers in the more than 200 health-related occupations.

The Monday session ended with a dinner sponsored by AMA Public Affairs Division and AMPAC, at which time Oregon's Republican U. S. Sen. Robert Packwood presented the challenging address, "You, Too, Can Be a Leader."

The Tuesday, October 7, session began with an Early Bird roundtable discussion breakfast featuring medically-oriented current events and the growing role of the individual auxiliary member.

This professionally organized Conference was quite worthwhile and instructive, and it is hoped that the three representatives from West Virginia can communicate the wealth of information we received to each Auxiliary throughout our State. It was well attended by representatives from every state. I thank you for permitting me to represent the West Virginia Medical Auxiliary as President Elect at this challenging educational meeting.—*Mrs. Robert J. Tchou, President Elect, Woman's Auxiliary to the West Virginia State Medical Association.*

Mrs. Joe N. Jarrett of Oak Hill, President of the Woman's Auxiliary to the West Virginia State Medical Association, witnessed Gov. Arch A. Moore's signing of a proclamation designating November 10-16 as Community Health Week in West Virginia. The proclamation noted that "there is a high quality of health care services and abundance of medical facilities and health resources throughout the State."

Ophthalmic Postgraduate Course At Cleveland Clinic

The Annual Conference of the Cleveland Clinic Department of Ophthalmology will be held December 10-11 in Cleveland.

Subject of the meeting will be "Concepts in Diagnosis and Management of Diseases of the Vitreous, Retina and Choroid."

Guest speakers will include Drs. Victor T. Curtin of Miami, Florida; Matthew Davis of Madison, Wisconsin; William S. Hagler of Atlanta, Georgia; and J. Donald Gass of Miami.

Also on the Cleveland Clinic postgraduate schedule for December is a seminar on "Respiratory Failure—Acute and Long Term Management" which will be held December 3-4.

Information about the Clinic's postgraduate program for 1969-70 may be obtained by writing to: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Pneumoconiosis Course Set For Charleston, Jan. 25

The Third Annual Mid-Winter Conference on Chest Diseases will be held at the Heart O' Town Motor Inn in Charleston on Sunday, January 25.

This year the program will be a symposium on Coal Workers Pneumoconiosis. Sponsors are the West Virginia State Medical Association, the West Virginia Thoracic Society and the West Virginia University Medical Center.

Drs. Joseph T. Skaggs and Ralph H. Nestmann, Charleston internists, are co-chairmen. They said registration will be limited to 100, and practicing physicians will be charged a fee of $10, which will include luncheon at the motel. Medical students, interns and residents will be fee exempt.

The following is the tentative program for the meeting:

"Definition and Epidemiology"—W. Keith C. Morgan, M. D., Associate Professor of Medicine, WVU Medical Center.

"Clinical and Physiological Studies"—N. LeRoy Lapp, M. D., Instructor in Medicine, WVU Medical Center.

"Immunological Studies"—Robert G. Burrell, Ph. D., Associate Professor of Microbiology, WVU Medical Center.

"Biochemical Studies"—Harold Resnick, Ph. D., Associate Professor of Biochemistry, WVU Medical Center.

There will also be a series of case presentations.

The program will begin at 10 A.M. and will be completed by 4 P. M. Application has been made to the American Academy of General Practice for accreditation.

Doctors Skaggs and Nestmann emphasized that physicians throughout the State are invited to register for the course.

A registration blank may be found elsewhere in this issue of *The Journal.*

Additional information may be obtained by writing to West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia 25324.

Looking Back 10 Years . . .

These physicians were appointed in 1959 to serve on the Program Committee for the 1960 Annual Meeting of the State Medical Association. Seated: the late Dr. Theresa O. Snaith of Weston; Dr. Seigle W. Parks, then of Fairmont and now of Charleston; and Dr. Kenneth G. MacDonald of Charleston. Standing: Dr. William A. Thornhill, Jr., of Charleston; and Dr. G. Thomas Evans of Fairmont.

'Response to Exercise' Monograph Issued by AHA

The American Heart Association has issued an 80-page publication based on a longitudinal study of adaptive changes in oxygen transport and body composition.

Entitled "Response to Exercise After Bed Rest and After Training," the investigation was conducted by Drs. Bengt Saltin, Gunnar Blomqvist, Jere H. Mitchell, Robert L. Johnson, Jr., Kern Wildenthal and Carleton B. Chapman.

The publication is intended to provide more light on the complex manner in which man adapts to muscular exercise. The study investigated the capacity of an individual to adapt to long periods of exercise, rather than measure a group of individuals at various stages over short periods of time. Both the capacity to return to normal activity after prolonged bed rest and, in the case of athletes, to resume training, are covered.

Of interest to cardiologists, internists, general practitioners, physiologists, psychiatrists, physical therapists and education specialists, the publication may be obtained through local Heart Associations or the AHA National Office, 44 East 23rd Street, New York, New York 10010.

Dr. Merle S. Scherr of Charleston (left) took a few moments to engage in some international diplomacy during a recent visit to Argentina for a medical meeting. He is presenting a West Virginia flag in the name of Gov. Arch A. Moore, Jr., to Dr. Jose Luis Cantini, Rector of the National University of Rosario. Doctor Cantini designated Doctor Scherr a Visiting Professor of the University and presented him with a medal in the name of the President of Argentina. Doctor Scherr presented a paper on asthma at the meeting held at the University.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1969

Dec. 5-6—Am. Rheumatism Assn., Tucson, Ariz.
Dec. 6-11—Am. Acad. of Derm., Bal Harbour, Fla.
Dec. 8-10—Sou. Surg. Assn., Hot Springs, Va.

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Jan. 11-14—Soc. of Thor. Surg., Atlanta.
Jan. 17-22—Am. Acad. of Orthopedic Surg., Chicago.
Feb. 8-9—AMA Cong. on Med. Ed., Chicago.
Feb. 14-18—Am. Acad. of Allergy, New Orleans.
Feb. 25-March 1—Am. Col. of Cardiology, New Orleans.

March 12-14—Sou. Soc. of Anes., Williamsburg, Va.
March 16-20—Am. Col. of Allergists, Bal Harbour, Fla.
March 20-21—AMA Cong. on Socio-Economics of Health Care, Chicago.
March 30-April 4—Am. Col. of Radiology, Dallas.

April 1-3—Maryland Medical, Baltimore.
April 6-8—Am. Assn. for Thoracic Surg., Washington.
April 10-12—Am. Soc. of Int. Med., Philadelphia.
April 12-17—ACP, Philadelphia.
April 13-16—Am. Acad. of Ped., Washington.
April 12-18—Am. Col. of Ob. & Gyn., New York.
April 15-18—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 16-17—Carolinas-Virginias Hosp. Conf., Columbia, S. C.
April 19-23—Am. Assn. of Neurological Surg., Washington.
April 24-26—W. Va. Chap., AAGP, Charleston.
April 27-29—Am. Surg. Assn., White Sulphur Springs.
April 27-May 2—Am. Acad. of Neurology, Miami Beach.
April 29-May 2—Am. Ped. Soc., Atlantic City.

May 11-15—Am. Psychiatric Assn., San Francisco.
May 10-14—Am. Urological Assn., Philadelphia.
May 11-15—Ohio Medical, Columbus.
May 24-27—Am. Thoracic Soc., Cleveland.
May 25-27—Am. Gyn. Soc., Hot Springs, Va.
May 28-30—Am. Oph. Soc., Hot Springs, Va.

June 13-14—Am. Diabetes, Assn., St. Louis.
June 21-25—AMA, Chicago.

July 17-18—Rocky Mtn. Cancer Conf., Denver.

Aug. 20-22—103rd Annual Meeting, W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.

Aug. 24-27—Am. Hosp. Assn., Chicago.

Sept. 11-19—Am. Soc. of Clin. Path., Atlanta.
Sept. 12-18—Col. of Am. Path., Atlanta.
Sept. 20-24—Am. Acad. of Oph. & Otol., Las Vegas.
Sept. 22-24—Ky. Medical, Louisville.
Sept. 25-Oct. 1—AAGP, San Francisco.

Oct. 4-8—Pa. Medical, Lancaster.
Oct. 5-9—Am. Acad. of Oph. & Otol., Las Vegas.
Oct. 11-14—Virginia Medical, Richmond.
Oct. 12-16—ACS, Chicago.
Oct. 17-21—Am. Soc. of Anes., New York.
Oct. 17-22—Am. Acad. of Ped., San Francisco.
Oct. 25-30—Am. Col of of Chest Phys., Las Vegas.

Nov. 16-19—Sou. Med. Assn., Dallas.
Nov. 29-Dec. 2—AMA Clinical, Chicago.
Dec. 5-10—Am. Acad. of Derm., Chicago.
Dec. 7-10—Sou. Surg. Assn., Boca Raton, Fla.

Your Heart Association can help you help your patients

Your patients and their families might have questions about the heart and blood vessel diseases. Your Heart Association has prepared a variety of pamphlets to assist you in answering their questions in simple non-technical language.

Produced under the guidance of leading cardiovascular specialists, these pamphlets deal with such subjects as heart attack, stroke, hypertension, rheumatic fever, congestive failure, inborn heart defects, varicose veins and other disorders. There are also pamphlets advising on risk factors related to heart attack, including persuasive arguments against cigarette smoking, and a fat-controlled, low-cholesterol diet plan for the general public.

Booklets on therapeutic sodium-restricted or cholesterol-lowering diets are also available on a physician's prescription only.

Ask your local Heart Association for a catalogue listing all these free materials and order a supply.

WEST VIRGINIA HEART ASSOCIATION
211 Thirty-Fifth Street, S. E.
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Courtesy of the Publisher.

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CLASSIFIED

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WANTED—Physician wanted to staff emergency room in a new hospital in Princeton. Progressive and growing community with many recreational facilities in the area. Contact the Administrator, Princeton Memorial Hospital, 1332 Mercer Street, Princeton, W. Va. 24740.

AVAILABLE—Board certified general surgeon with good thoracic surgery training presently in practice will consider any general surgery position in West Virginia. Write PJO, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Physician seeking full or part-time employment in clinic, hospital or as associate in practice. Licensed in West Virginia. Contact EWF, The West Virginia Medical Journal, Box 1031, Charleston, West Virginia.

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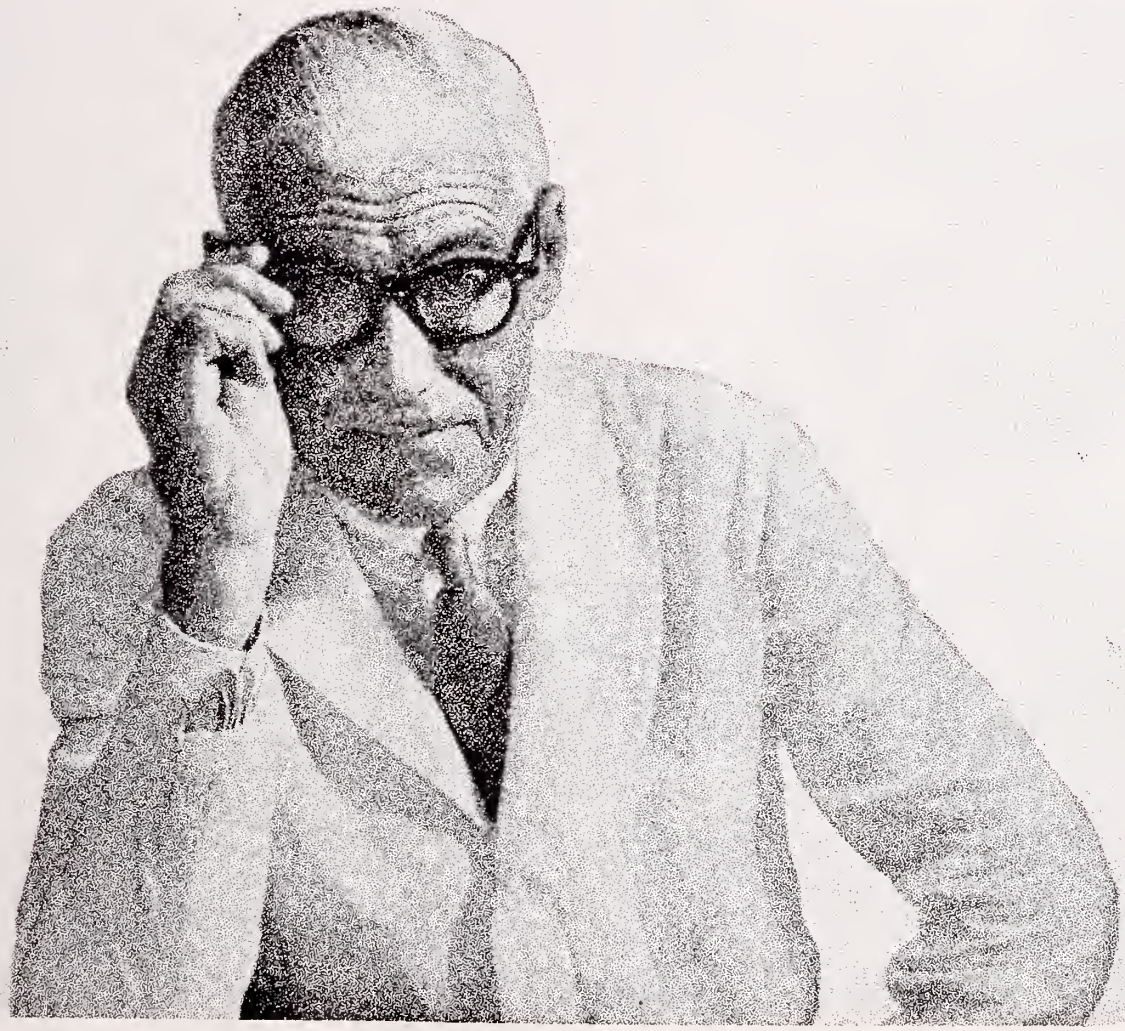

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